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ABSTRACT

The issues of this quarterly publication and year end supplement contain professional articles on topics that concern at risk youth and emphasize preventive measures. Number 1 highlights the challenges facing gay, lesbian, and bisexual youth in schools. Many schools have nothing in their curricula to help provide an understanding of these issues due to the politics and cultural misunderstandings of sexual identity. Number 2 focuses on teenage tobacco use, an important public health concern. It contains an overview of the prevention strategies that have attempted to discourage youth tobacco use and explains the social influence model that entices youth to regular smoking is explained. Volume 3 looks at the prevalence and history of homeless youth. It includes an examination of the educational needs of middle school homeless youth. Number 4 considers many issues surrounding teenage depression including how to recognize it; the impact of race identity on depression; gender differences; risk factors; and resilience. The annual supplement features a question and answer session on the topic of teenage self injurious behavior. It also contains book reviews and numerous web resources and publications. A cumulative topic index is included that reflects the past 8 years of the publication. (Contains 15 tables.) (JDM)

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The Prevention Researcher, 2001
Volume 8, Numbers 1-4

Steven Ungerleider, Editor

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The PREVENTION RESEARCHER

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Lesbian and Gay Adolescents: Identity Development

By Caitlin Ryan, M.S.W. and Donna Futterman, M.D.

Lesbian and gay adolescents come from all racial and ethnic groups, all socioeconomic levels, and all religious denominations. They live in large cities, small towns, and rural communities. They are student leaders, athletes, and active members of civic groups as well as school dropouts and street youth. For the most part, lesbian and gay adolescents are indistinguishable from their heterosexual peers—in fact, most are invisible.

Homosexuality and Sexual Orientation

As defined by the American Academy of Pediatrics, "homosexuality is the persistent sexual and emotional attraction to members of one's own gender and is part of the continuum of sexual expression." It has been reported in most societies throughout recorded history. During the 1930s and 1940s, Kinsey's landmark research identified a spectrum of human sexual behavior that ranged from sexual attraction and behaviors with the opposite sex (heterosexuality) to both sexes (bisexuality) to the same sex (homosexuality). This pattern of physical behavior and sexual attraction is called *sexual orientation.*

Because the repercussions of disclosing one's homosexuality can be extremely negative, including loss of job, loss of family and friends, victimization, and violence, many lesbians and gay males share their sexual identities only with other gay people. This limits awareness of the diversity of human sexuality, while perpetuating a false assumption that all youth are heterosexual.

Identity Development

During adolescence, youth begin to consolidate adult identity. Identity is a complex integration of cognitive, emotional, and social factors that make up a person's sense of self. These include gender (personal sense of being male or female), sex roles (social and cultural expectations of masculinity and femininity), personality (individual traits and disposition), and sexual orientation.

Adolescence is a time of exploration and experimentation; as such, sexual activity does not necessarily reflect either present or future sexual orientation. Confusion about sexual identity or sexual orientation is not uncommon in adolescents. Many youth engage in same-sex behavior; attractions or behaviors do not mean that an adolescent is lesbian or gay. Moreover, sexual activity is a behavior, whereas sexual orientation is a component of identity. Many teens experience a broad range of sexual behaviors that are incorporated into an evolving sexual identity, consolidated over a period of time.

Overly interpreting the significance of adolescent sexual behavior in relation to sexual identity should be avoided. For example,

- Many lesbian/gay adolescents are not sexually experienced.
- Many lesbian/gay adolescents may have heterosexual experiences.
- Heterosexual adolescents may have homosexual experiences.
- Some adolescents may self-identify as lesbian or gay without ever having had homosexual (or heterosexual) experiences.

> ***Lesbian and gay adolescents and adults frequently describe a sense of feeling "different" from early childhood.***

Lesbian and gay adolescents and adults frequently describe a sense of feeling "different" from early childhood. As they age and develop cognitively, many lesbian and gay youth begin to understand the nature of their difference and society's negative reaction to it. In identifying and learning to manage stigma, these adolescents face additional, highly complex challenges and tasks. Lesbian and gay adolescents must learn to manage a stigmatized identity without active support and modeling from parents and family. Youth stigmatized because of race and ethnicity learn coping behaviors and survival skills from parents, families, and cultural groups that provide nurturance and support against intolerance and discrimination. This support creates a buffer against hostility and humiliation experienced within the larger society, while providing the framework for building self-esteem and a positive sense of self. Even with positive parental support, minority adolescents and adults struggle with the powerful results of stigma that have significant impact on health and mental health.

(Continued on Page 3)

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From the Editor's PC

Dear Colleagues,

Welcome to volume 8(1) of *The Prevention Researcher.* In this issue, we highlight the challenges facing gay, lesbian and bisexual youth in today's schools. We chose this topic because there is little in the literature and even less material available in schools for students who are struggling with gay, lesbian and bisexual issues. Some schools have strong curricula in providing an understanding of these issues; many schools have nothing due to the politics and cultural misunderstandings of sexual identity.

Thus, we asked several experts to help us better understand these issues. Contributing authors for this issue include: Caitlin Ryan, M.S.W., director of Policy Studies at the Institute on Sexuality, Inequality and Health at San Francisco State University; Donna Futterman, M.D., associate professor of pediatrics at Albert Einstein College of Medicine; Robert Owens, Ph.D., professor of speech pathology at State University of New York at Genesco; Janet Fontaine, Ph.D., associate professor of Counseling at Indiana University of Pennsylvania, Indiana; Robb Travers, Ph.D. candidate at University of Toronto's Department of Community Health; and Margaret Schneider of the Ontario Institute for Studies in Education.

All of these experts shed light on the difficult lives of youth questioning their sexual identity. We are most appreciative of their efforts in this arena.

Additionally, you will notice we have changed our format and increased to a 16-page publication so that we can provide you with more information on each of the topics we cover. As always, please visit us on the web at www.TPRonline.org for more information, resources, and reference material to all of our articles over the past seven years.

Steven Ungerleider, Ph.D.
Psychologist/Editor, *The Prevention Researcher*

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- Teenage Depression
- Involving Parents in Prevention and Intervention

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Recycled Paper

Understanding the concept of lesbian/gay identity requires an awareness of adolescent sexual behavior and knowledge of both the common coping mechanisms for managing a stigmatized identity and the process of identity development in lesbian and gay youth. Same sex behavior is more common among adolescents than adults; however, fewer adolescents than adults label themselves lesbian or gay. They are not only fearful of rejection and discrimination, but also may feel uncertain or may be unaware of their sexual orientation. A large-scale study of Minnesota junior and senior high school students found that although more than 88% described themselves as predominantly heterosexual and 1% said they were either bisexual or predominantly homosexual, more than 10% were unsure of their sexual orientation. Uncertainty declined with age, from 26% of 12-year-olds to 5% of 18-year-olds. Older adolescents were more likely than younger peers to report homosexual identities, attractions, and behaviors.

Studies of adolescent sexual orientation show that the age of self-identification as lesbian or gay has been dropping steadily (Table 1). Unlike older lesbians and gay men whose survival often depended on separating their social, professional, and emotional lives, today's generation of lesbian, gay, and bisexual youth has an opportunity to live fully integrated lives. However, self-identification as lesbian or gay at younger ages also means greater stress, more negative social pressure, greater likelihood of victimization, and greater need for support, particularly from nonjudgmental and informed adults who can offer appropriate guidance, health education, and referrals. The need for support is particularly critical to avoid isolation when adolescents begin to question their sexual identity (Table 2).

Coming Out: Developmental Model

Coming out—acknowledging one's lesbian/gay identity—is an interactive, ongoing process through which lesbians and gay men recognize their sexual orientation and integrate this awareness into their lives. Several models of identity development have been proposed to describe the coming out process. Nearly all models (1) recognize the impact of stigma, which affects both the formation and expression of homosexual identity; (2) unfold over a period of time; (3) involve increasing acceptance of a "homosexual" identity; and (4) include disclosure to non-gay persons.

Earlier staged models of coming out provide an understanding of the process of sexual identity development. However, these models were developed based on the experiences of mostly white middle and upper-middle class adults and may not reflect the experience of today's generation of lesbian and gay (or "queer") youth.

> ***The need for support is particularly critical to avoid isolation when adolescents begin to question their sexual identity.***

Earlier models suggest that children who grow up to be lesbian or gay often experience feelings of being "different" from peers. Differences are based on gender-neutral or atypical gender-role choices or behaviors rather than awareness of sexuality. Such feelings can result in an early sense of social isolation. Children and adolescents have also internalized widespread misconceptions about homosexuality. The inability to identify with widespread stereotypes and the lack of access to openly gay adult role models, results in identity confusion and cognitive dissonance—a sense that what one feels or perceives is out of step with the perceptions of others. Lack of opportunity for socialization with lesbian and gay peers increases social isolation and constricts key aspects of development; while heterosexual peers are developing communication and self-disclosure skills that enhance ability to interact and form intimate relationships, many lesbian and gay youth are learning how to hide core aspects of identity.

Many adolescents try to hide their lesbian/gay identity through various coping strategies and behaviors, passing as heterosexual in most or all of their interactions. Other coping strategies include denying same-sex feelings, trying to avoid situations that might confirm sexual identity, trying to change sexual orientation by dating or engaging in heterosexual

TABLE 1

Average Age (Years) Event Occurs

	Adults* (Retrospective Studies)		Adolescents† (Prospective Study)	
Behavior/Identity	**Males**	**Females**	**Males**	**Females**
First awareness of homosexual attraction	13	14-16	9	10
First homosexual experience	15	20	13	15
Self-identification as lesbian or gay	19-21	21-23	16	16

* From R.R. Troiden (1998). Homosexual identity development. *Journal of Adolescent Health* 9: 105.

† From G. Herdt, & A. Boxer (1996). *Children of Horizons.* 2nd ed. Boston: Beacon Press.

TABLE 2

Isolation Experienced by Lesbian and Gay Youth

Social	Feel alone in social situations (with family, peers, in school or religious settings). Feel they have no one to talk to. Fearful of discovery.
Emotional	Feel they must be vigilant at all times, increasing their emotional distance. Feel separated affectionally and emotionally from others, especially family. Fear that friendships will be misunderstood by same-sex friends or may give away their secret.
Cognitive	Lack accurate information about homosexuality, including appropriate role models. Base their information of other lesbians and gay males on crude stereotypes.

From A.D. Martin & E.S. Hetrick (1987). Designing an AIDS risk reduction program for gay teenagers: Problems and proposed solutions. In D. Ostrow (Ed). *Biobehavioral Control of AIDS.* New York: Irvington Publishers.

activity, using alcohol or drugs to repress same-sex feelings or behaviors, or trying to rationalize behavior as being only temporary. As they acknowledge their lesbian/gay identity, many adolescents increasingly seek out accurate information and support.

Adolescents are increasingly self-identifying as lesbian or gay at younger ages. Access to the Internet, which includes information and support for non-heterosexual youth, is helping facilitate this early self-identification. Additionally, access to a well-defined community providing supportive social, recreational, and religious activities helps to dispel negative stereotypes and provides a broader range of life choices. Interaction also provides support for managing stigma, learning how to deal with discrimination, violence, and other negative experiences that routinely occur within mainstream society.

Lesbian and gay youth who lack adequate support or who remain unaware of positive options for living integrated, productive lives may develop maladaptive coping behaviors that persist into adulthood placing them at increased risk for serious health and mental health problems. These include substance abuse, depression, suicide, and HIV/AIDS.

Self-acceptance generally culminates with incorporating sexual identity into various aspects of one's life. As with other stages of identity development, prior experiences, access to resources and information, the availability of support, and personal vulnerabilities and resilience determine the degree of identity integration that occurs.

More recent theorists contend that staged models of sexual identity development are too linear and fail to account for other aspects of identity such as gender, race, and ethnicity. Moreover, these theorists caution that widespread disclosure should not be construed as the only measure of integrated identity. Many factors such as legal and economic realities, racial/ethnic group membership, religious background, geographic area, family situation, and support systems determine the extent to which disclosure may be possible or desirable.

Ethnic and Racial Minorities

Ethnic minority youth face additional stressors and challenges in consolidating sexual, racial, and ethnic identities. Within each cultural and ethnic group, sexuality holds different meanings, and lesbian/gay identity is shaped by various factors. These include attitudes, values, and beliefs about sexuality, stereotypes about gender and sex roles, responsibilities for childbearing, religious values, degree of acculturation or assimilation into mainstream society, and the importance of family and ethnic communities in providing acceptance and support.

For members of ethnic minority groups, race and ethnicity form core components of identity; together with gender and sex roles (which are also culturally based), they frame an evolving sense of self. By the time an adolescent becomes aware that same-sex feelings and behaviors may signal homosexual orientation, primary identity—race/ethnicity—is well established. In a society that discriminates on the basis of race and ethnicity, strong connections with family and ethnic community are essential for survival. However, support is rarely available for an adolescent's homosexual identity. For many ethnic groups, being lesbian or gay may represent rejection of one's ethnic heritage. Only among some American Indian tribes is homosexuality acknowledged in language and tribal history as part of a third-gender cultural tradition, although acceptance has largely been replaced by more negative mainstream attitudes.

Ethnic minority lesbian and gay youth are required to manage more than one stigmatized identity, which increases their level of vulnerability and stress. To meet their emotional, educational, and practical needs, they must learn to interact with three very separate communities that have different and often conflicting values. These include their ethnic community, the predominantly white lesbian and gay community, and mainstream society. Each community provides access to important resources, but all devalue part of the youth's identity. Balancing the needs and demands of three separate worlds often requires lesbian and gay ethnic minorities to choose or prioritize allegiances, which results in prioritizing or suppressing, rather than integrating, key aspects of identity.

> ***While heterosexual peers are developing communication and self-disclosure skills… many lesbian and gay youth are learning how to hide core aspects of identity.***

Bisexuality

Bisexuality has emerged more recently as a separate cultural identity from lesbian, gay, and heterosexual identity, and understanding of bisexual identity and its development is still evolving. In addition to individual identity, *bisexuality* also refers to behavior and often represents an aspect of lesbian or gay identity development (many lesbian or gay adults and adolescents describe bisexuality as a stage of identity development prior to identifying as lesbian or gay). It is unclear to what extent adolescents actually consolidate a separate cultural bisexual identity or whether bisexual identity is consolidated in adulthood.

Definitions

Come Out: Recognize, acknowledge same-sex feelings; disclose lesbian/gay identity to others.

In the Closet/Closeted: Pass as heterosexual; unresolved sexual identity.

Homophobia: Irrational fear, hatred, prejudice, or negative attitudes towards homosexuals or homosexuality; institutionalized fear, hatred, prejudice, or negative attitudes towards homosexuals or homosexuality that result in invisibility, discrimination, neglect or mistreatment.

Heterosexism: Denial, denigration and stigmatization of non-heterosexual identity, behavior, relationships, or community; often expressed in subtler forms than homophobia, such as the absence of support and neglect rather than overt prejudice.

A few researchers have explored bisexual identity development in adults, and findings suggest a different developmental pattern than for lesbians and gay males. Although studies show a broad range of behaviors, for most persons who identify as bisexual, this identity appears to be added after heterosexual identity, and self-labeling generally occurs at a later age than for lesbians and gay males (mid-to-late 20s). In addition, many people may engage in bisexual behavior (sexual activity with same- and opposite-sex partners) without self-identifying as bisexual.

Experiences With Disclosure

A critical aspect of identity management for all lesbian and gay youth is learning to assess when and with whom they can safely disclose their lesbian or gay identity. Negative experiences related to disclosure make it imprudent to come out in many settings.

The decision to disclose one's lesbian or gay identity, particularly to parents, may have long-term consequences. Most adolescents are dependent on their parents for financial and emotional support. Although coming out can reduce stress and increase communication and intimacy in relationships, disclosure during adolescence may result in abandonment, rejection, or violence when parents abruptly learn or discover that their child is lesbian or gay. Adolescents who are considering coming out to their parents should be encouraged to explore their reasons carefully before doing so. Even parents who try to be supportive need time, access to accurate information, and an opportunity to process what for most will be a distressing and guilt-provoking experience.

Nevertheless, disclosure plays an important role in identity development and psychological adjustment, decreasing isolation while teaching and reinforcing identity management skills. An understanding of common disclosure patterns can help in assessing available support, family dynamics and resource needs.

When disclosure is voluntary, lesbians and gay males usually come out first to those they perceive as less threatening (emotionally, physically, and economically), usually their friends. Although lesbian and gay friends are more likely confidants, many adolescents, particularly those who are younger, have no friends who are lesbian or gay. Unfortunately, rejection by heterosexual friends appears common. In a 14-city survey, nearly three-fourths of lesbian and gay youth first disclosed their sexual identity to friends, and nearly half (46%) lost a friend after coming out to her or him. Disclosure to siblings and other close family members usually precedes coming out to parents. Although, some lesbian and gay adults never tell their parents, just as many tell very few or none of their coworkers.

A study of gay-related stress among adolescents found that the most common stressors were coming out to parents and siblings, having their sexual orientation discovered by parents or siblings, being discovered by friends and being ridiculed because they were gay.

> ***The decision to disclose one's lesbian or gay identity, particularly to parents, may have long-term consequences.***

Among ethnic minority lesbians and gay males, community pressure to conceal lesbian or gay identity generally results in lower visibility overall. Although these adolescents more likely will tell close friends, they usually perceive disclosure to parents, extended family, and the broader ethnic minority community as being too threatening.

Conclusion

The process of self-identifying as lesbian or gay during adolescence can take a number of years, starting before puberty when lesbian and gay youth may begin to feel "different" from others and culminating in self-acceptance through integrating sexual identity into various aspects of one's life. Access to adult and peer support, accurate information and resources can help enhance coping skills, self-esteem and positive help-seeking behaviors. ↝

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This article is condensed from the chapter "Lesbian and Gay Adolescents—Identity Development" in *Lesbian & Gay Youth: Care & Counseling*, by Caitlin Ryan and Donna Futterman, Columbia University Press, 1998. It appears here with permission.

How Straight Coaches Can Support Lesbian, Gay, and Bisexual Student Athletes

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Experiences, Vulnerabilities and Risks of Lesbian and Gay Students

by Caitlin Ryan, M.S.W. and Donna Futterman, M.D.

A primary task of identity development for lesbian and gay adolescents is learning to manage a stigmatized identity. Although there are clear differences between sexual and racial identities, similar developmental tasks are required of ethnic and racial minorities who must transform a stigmatized identity into a positive one. For lesbian and gay youth who experience stigma related to sexual identity with the onset of same-sex feelings, this task is no less difficult, and it is particularly stressful for lesbian, gay and bisexual youth of color.

Internalized as self-hate and low self-esteem, stigma may be acted out behaviorally, increasing high-risk behaviors such as unprotected sex and substance abuse, and intensifying psychological distress and risk for suicide. Although the vast majority of lesbian and gay adolescents grow up to lead healthy, productive lives, the experience of acknowledging same-sex feelings and integrating a positive lesbian/gay identity represents a significant developmental crisis for most individuals, regardless of age.

Lesbians and gay males who have integrated a positive identity show better psychological adjustment, greater satisfaction, and higher self-concept, with lower rates of depression or stress than gay people in conflict with their identity. Nevertheless, identity development takes place over time, and integrating a positive identity requires access to supportive peers and adults, accurate information, and connection to a community in which acceptance and validation are provided. Stigma does not change; however, the way one perceives and responds to its dehumanizing effects does.

Living With Stigma

Although stigma may be either visible or invisible, some health and social costs are surprisingly similar. Goffman's work on social stigma discusses the stress associated with managing stigmatized identity: *visible* stigma such as race requires a range of coping skills to respond to prejudice and discrimination, whereas *invisible* stigma such as undisclosed homosexuality requires careful monitoring of all interactions and an awareness that relationships are based on a lie that could be exposed at any time. For ethnic minority lesbians and gay males the stress is even greater.

The stress of hiding one's identity can be extreme; even casual conversations must be monitored and screened. Fear of discovery restricts relationships and shapes behavior. Although hiding may appear to protect closeted lesbians and gay males, it isolates them from access to a supportive community, sensitive health and mental health services, and positive role models. Hiding is also associated with substance abuse, suicide, depression, and other high-risk behaviors.

However, not all gay people are invisible; increasingly, many choose to integrate their social and work lives rather than pass as heterosexual, while others may have been "discovered" and exposed, or are assumed to be gay since they fit common stereotypes. Openly gay or stereotypical lesbians and gay males are at risk for discrimination, violence, rejection by family and peers, and the negative mental health and behavioral effects of internalized homophobia that range from low self-esteem to self-hate. Although internalized homophobia is buffered by access to a supportive community, positive experiences, and role models, its residual effect often remains as an underlying vulnerability.

Prejudice

In studying the effects of prejudice on socially oppressed groups, Gordon Allport describes the process of stereotyping and labeling that justifies negative attitudes and discrimination, and often leads to violence. Allport found that members of victimized groups develop a series of coping strategies in response to prejudice; these include withdrawal and passivity, vigilance, self-hate, denial of membership in one's group or aggression against one's group, and expectations of rejection, discrimination, and violence. All are common coping responses to managing the stigma of a lesbian or gay identity, particularly in earlier stages of identity development. Adults working with lesbian and gay adolescents should understand the role of stigma in enhancing vulnerabilities and risks for various diseases and health problems.

> ***Undisclosed homosexuality requires careful monitoring of all interactions and an awareness that relationships are based on a lie that could be exposed at any time.***

Social Disapproval, Discrimination, and Violence

Although negative attitudes toward lesbian and gay people are changing, discrimination persists in the lives of lesbians and gay males of all ages. Ethnic minority lesbian and gay males, and lesbian and gay youth and young adults are at highest risk. Adolescents who are open about their sexual orientation, who are suspected of being lesbian or gay, or who behave in ways associated with lesbian or gay stereotypes are the most frequent victims. Moreover, since the advent of AIDS, violence against lesbians and gay males has steadily increased.

Surveys of bias-related experiences among adult lesbians and gay men show that during their lifetimes, more than half have experienced some kind of violence because of their sexual orientation. According to the 1995 Massachusetts Youth Risk Behavior Survey, during the past month, lesbian, gay, and bisexual youth were more than four-and-a-half times as likely as heterosexual youth to have missed school for fear of personal safety or to have been threatened with a weapon at school (see Table A). Among adolescents receiving services at a New York City agency for lesbian and gay youth (of whom 84% were Black or Latino), 2 out of 5 had been physically assaulted, and more than three-fifths of gay-related violence occurred in their homes.

Effects of Victimization

Fearful of discovery or further abuse, many lesbian and gay youth face the aftermath of victimization alone or with help from a few friends or a supportive adult, when available. Typically, depression, anxiety, fear, low self-esteem, and self-blame follow victimization. A more serious complication may be post-traumatic stress disorder. Those who are seriously hurt have no choice but to seek help from others; doing so, however, may cause further victimization since having to reveal sexual orientation may lead to rejection, ostracism, violence, or being forced out of their homes. An added threat for closeted gay youth who witness pervasive anti-gay abuse in school and community settings is the realization that this could happen to them. Fear of discovery increases anxiety, thus reinforcing their sense of devaluation and isolation and encouraging them to hide.

Moreover, witnessing bias-related discrimination and violence through the media, hearing reports of what happens to others, and having personal experiences with discrimination and abuse have a sobering impact on such key developmental tasks as career development and life choices. Mental health providers and youth service workers have observed for some time that lesbian and gay adolescents face restricted life choices as a result of prejudice, discrimination, and internalized homophobia. For some lesbian and gay youth, ridicule and physical abuse at school and inadequate support or disapproval at home may result in poor grades, truancy, or dropping out of school.

Career development, which is intimately linked to self-concept and identity, is also affected. Believing they will never be accepted in mainstream society, some lesbian and gay youth abandon career or educational goals, and others may opt for stereotypic jobs. Although adolescents are socialized to strive for common expectations and ideals, lesbian and gay youth may perceive that such goals are only relevant or achievable by their heterosexual peers. For example, youth may perceive that they will be unable to work in certain jobs (e.g., business, trade or professional jobs) and be openly gay, as many older lesbians and gay men who sought to avoid discrimination and economic sanctions by compartmentalizing various aspects of their lives.

Runaways, "Throw-Aways," and Institutionalized Youth

Rejection by family and friends and the cumulative effect of harassment, ridicule, and physical abuse cause some lesbian and gay youth to run away, whereas others may be forced out of their homes after parents discover their sexual orientation. Although the actual number of lesbian/gay runaways and "throw-always" is not known, some estimates suggest that 1 in 4 street youth may be lesbian or gay. Agencies serving street youth in Los Angeles estimate that 25-35% of homeless youth there are lesbian or gay, and in Seattle, 40% of homeless youth are estimated to be lesbian or gay.

TABLE A

Victimization Experiences of Youth, Grades 9-12
Massachusetts Youth Risk Behavior Survey

	Lesbian, Gay & Bisexual Youth	Heterosexual Youth
Missed school during past month because they felt unsafe	25.1%	5.1%
Threatened with a weapon at school	32.7%	7.1%
Property damaged at school	50.5%	28.7%
Fighting (past 12 months)	68.1%	37.6%
Fighting requiring medical treatment (past 12 months)	14%	4.1%

From R. Garofalo, C. Wolf, S. Kessel, J. Palfrey, R.H. DuRant. (1998). The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics*, 101(5), 895-902.

The stressors that lead lesbian and gay youth to leave home and school also increase the potential for exploitation. Without employable skills, some turn to prostitution, drug dealing, or other illicit activities for survival which may get them involved in the juvenile justice system. Others enter foster care, youth homes, and social service systems where they are at risk for further discrimination, neglect, harassment, and violence. A study of lesbian/gay youth in New York City's child welfare system showed that more than two-thirds (70%) had been victims of violence because of their sexual orientation, while more than half (56%) said they had stayed on the streets, at times, where they felt safer than living in group or foster homes.

> ***For some lesbian and gay youth, ridicule and physical abuse at school and inadequate support or disapproval at home may result in poor grades, truancy, or dropping out of school.***

Health Providers' Attitudes and Perceptions

Many lesbian and gay clients are fearful of disclosing their sexual orientation to health care providers and believe that doing so will result in rejection, discrimination, or poor care. Unfortunately, many studies confirm their fears. Research on provider training, attitudes, and perceptions of lesbian and gay clients demonstrate negative and homophobic attitudes among a sizeable proportion of providers in a variety of disciplines.

Negative attitudes and perceptions, and discriminatory care have life-long implications for lesbian and gay youth. During adolescence, attitudes about health, self-care, and help-seeking behaviors are formed. Negative or discriminatory experiences can undermine provider-client trust, cause lesbian/gay clients to withhold important information, avoid routine or preventive care, and delay seeking help until health problems are well advanced. Such behaviors are routinely observed in lesbian and gay clients of all ages.

By keeping sexual orientation secret, many lesbian and gay adolescents seek to protect themselves from potential abuse. However, this information is an important part of their medical histories that helps providers understand what types of tests may be indicated, what kinds of referrals may be appropriate, and what types of health information are needed. Despite the relevance for treatment and care, few providers routinely ask clients about their sexual orientation.

Denial and Minimization

A common response to an adolescent's concerns that she or he might be lesbian or gay is to deny or minimize such concerns. This response is generally based on the misconception that homosexual behavior is merely a "phase" that adolescents grow out of. Some adults may fear that discussing same-sex concerns will actually encourage homosexuality or potentially "cause" an adolescent to "become" homosexual. Although more adolescents are sexually active with same-sex partners than will ultimately consolidate adult homosexual identity, such fears are false. When expressed or acted out by teachers and counselors, they may undermine the student-counselor relationship and result in increased anxiety, secrecy, and failure to share pertinent information.

Health

The medical needs and concerns of lesbian and gay youth are similar to those of heterosexual teens; however, denial and fear of discovery make lesbian/gay youth less likely to seek medical care or to acknowledge homosexual orientation or sexual activity. Some concerns, such as substance abuse, are more common to vulnerable and stigmatized groups, and several studies suggest that lesbians and gay males are at high risk for substance abuse. More troublesome for lesbian and gay youth is use of alcohol and drugs to cope with stigma-related stress, which may heighten vulnerability for chemical dependency in later years. Use of alcohol and drugs is also associated with high-risk sexual behaviors and HIV infection.

Lesbian and gay youth are also victims of bias-related crime and assault. However, the reason for assault may be overlooked by providers rendering follow-up care. Hate crimes and anti-gay violence, in particular, have behavioral, psychological, and somatic sequelae, which heighten vulnerability and risk for health and mental health problems. Without appropriate follow-up care, including accurate assessment and referral for needed counseling and support, survivors may internalize the assault and try to deny or minimize its impact, thus intensifying psychological or physical problems. Because adolescent victims of anti-gay violence are not likely to reveal why they were attacked, providers should consider this possibility and carefully assess follow-up counseling and support needs when treating youth who have been assaulted or raped.

Mental Health

Studies of lesbian and gay adolescents show broad use of counseling services, when available. Reasons for seeking mental health services commonly include issues related to sexual orientation, family conflict, concerns with relationships, substance abuse, depression, and anxiety; referrals are also made for attempted suicide and conduct disorders.

Many, though not all of these problems, emerge as adolescents begin to confront the stigma of homosexuality and struggle with reframing negative myths and misconceptions. Without an awareness of positive options for relationships, education, and career, lesbian and gay youth have difficulty imagining satisfying, productive lives. Common psychological reactions include adjustment problems, impaired psychosocial development, family alienation, inadequate interpersonal relationships, alcohol and drug abuse, depression, suicidal ideation, and sexual acting out. Lack of support and inaccurate information about homosexuality further compound these problems.

With appropriate support, including access to accurate information, assistance in developing positive coping and social skills, gradually exploring sexuality and enhancing the quality of interpersonal relationships, issues of sexual identity will ultimately resolve.

Pre-existing vulnerabilities engendered by dysfunctional or addicted parents, emotional deprivation, physical and sexual abuse, severe stress, and prejudice may inhibit development of a positive gay identity. Moreover, adolescents with such histories may comprise the majority of youth who attempt or complete suicide or who experience serious chemical dependency. Regardless of prior trauma, however, the reported prevalence of suicidal ideation and attempted suicide among lesbian and gay youth is alarmingly high. Based on community studies, reported suicide attempts among lesbian and gay youth range from 20-42%, compared with estimated rates of 8-13% among high school students in general. These rates remain consistently high regardless of sample, geographic area, or time period. In addition, lesbian, gay, and bisexual youth, and those who reported same-sex experiences were four times as likely as their heterosexual peers to have attempted suicide during the past year according to the 1995 Massachusetts Youth Risk Behavior Survey. Similar results were found in other recent population-based studies.

Attempts to Reverse Sexual Orientation

Although the American Psychiatric Association removed homosexuality from its list of mental disorders more than twenty years ago, efforts to change sexual orientation persist. Generally unsuccessful over time, attempts to change sexual orientation raise many ethical concerns and often contribute to negative self-esteem and mental health problems. Experts in adolescent medicine recommend against such attempts, which are further cautioned against by the American Academy of Pediatrics, and other major professional associations.

Conclusion

Besides typical adolescent concerns, lesbian and gay youth must also deal with issues related to stigma, including prejudice, victimization, rejection by family and friends, negative attitudes of health care providers, denial and minimization by adults, and lack of support and accurate information about health risks, sexual identity and life chances. In spite of these challenges, most grow up to lead satisfying, productive lives. Counselors and health care providers should become familiar with these issues to provide appropriate care and support.

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This article is condensed from the chapter "Experiences, Vulnerabilities, and Risks" in *Lesbian & Gay Youth: Care & Counseling*, by Caitlin Ryan and Donna Futterman, Columbia University Press, 1998. It appears here with permission.

Counseling With Lesbian, Gay and Bisexual Youth

by Robert E. Owens, Jr., Ph.D.

The attractive, young African American student sat across from me in my college office. She was tired. Tired of fighting racism in all its many forms.

"What would you change?" I inquired rhetorically.

"Me," she replied without hesitation. "I wish I was white."

"No!" I shot back. "The problem isn't yours; there's nothing wrong with you."

In that quick instant she had revealed the very kernel of the problem of being different in our culture. The victim is made to feel somehow responsible. The majority attitude becomes internalized by the person with difference.

No group internalizes that stigma more than lesbian, gay, and bisexual (LGB) youth. In a high school culture where the brand of sneakers can result in being ostracized, this difference can lead to isolation, violence, drug and alcohol abuse, homelessness, and even suicide. Counselors and educators have a major role to play in the adjustment of LGB teens and in changing the culture of American schools.

We should first define some terms and outline the process of "becoming" lesbian, gay, or bisexual. There are three aspects of sexual being: sexual orientation, sexual behavior, and sexual identity. Each is independent but related to the others.

Sexual Orientation is a consistent pattern of sexual feelings, affectional attractions, thoughts, fantasies, and emotional and romantic feelings. It is a sense of inner identity. The distinction between behavior and orientation or between "doing" and "being" is very important.

Sexual Behavior is not a determiner of either orientation or identity and is more dependent upon the cultural and situational context and upon personal needs.

Sexual Identity is a consistent, enduring sense of one's own sexuality and establishment of self-identification.

Integration occurs when all three aspects of sexuality—orientation, behavior, and identity—are aligned.

The three most common coping strategies in dealing with a lesbian or gay identity are repression of desires, suppression of homosexual impulses, and acceptance and disclosure to others. Repression, which tries to prevent same-sex desires, offers the youth no opportunity to integrate sexual desires and sexual identity. Suppression tries to override these same-sex desires. The result is a moratorium that delays positive LGB identification. "Passing" as a heterosexual is the most common adjustment. Accepting one's homosexuality is the optimal strategy. Unfortunately, society encourages lesbian and gay teens to adopt strategies that subject them to psychological stresses that can affect their well-being. Since societal supports are rare, teen same-sex relationships are often secretive and short-lived.

Self-identification, which in the recent past usually occurred between the ages of 16-21, is occurring even earlier today, especially in large urban areas. Self-identification can be viewed as a two-step process in which a youth first accepts her or his sexual identity and then integrates that identity with personality and self-concept.

"Coming out" is a developmental process, a self-affirming rite, through which LGB individuals recognize their sexual orientation, develop positive feelings, and integrate this knowledge into their lives. The process occurs every time a lesbian, gay, or bisexual person shares her or his sexuality with another person. For many, coming out is a "rite of passage" into a well-adjusted adulthood. Although coming out in high school can be social suicide, more and more adolescents view it as a badge of honor or courage and an expression of individuality. Some youth are coming out as early as age 14. As a result, the challenges inherent in self-disclosure are now becoming associated with the problems of adolescence.

Amazingly, many LGB youth and their families navigate the issue of LGB development with little need of outside assistance. For those who seek professional assistance, the importance of and their need for this service can not be overstated. Helping LGB teens cope with the daily stresses in their lives and with the cumulative effects of homophobia requires a holistic approach that integrates all aspects of the person in a nonjudgmental manner.

> ***Sexual orientation… is a sense of inner identity. The distinction between behavior and orientation or between "doing" and "being" is very important.***

Affirming a positive LGB identity is particularly difficult and consumes a lot of energy. Societal and familial expectations are all heterosexual. No societal supports or opportunities to develop healthy sexual/intimate same-sex relations exist. If heterosexual dating is pursued, the price is one's authenticity.

Guidelines for Counseling the Individual Adolescent

The following section is an outline for effective counseling with LGB youth. These few hundred words are no substitute for professional training and experience. So-called "change" therapies are not discussed, because these interventions

1) are ineffective in long-term scientific studies,
2) target behavior not orientation,
3) serve to increase repression, and,
4) are counter to the goal of self-acceptance.

Heterosexual readers should visualize being forced to engage in homosexual behavior to imagine change techniques.

Educate Yourself

Effective counselors are comfortable enough with their own sexual feelings to be at ease discussing intimate sexual issues, and are truly unbiased. Counselors can utilize the resources of the local LGB community, national organizations, hotlines, and helplines to learn more.

Inexperienced counselors may be confused by the novelty of this topic, by the belief that ignoring "it" will make it go away, and by fear. The greatest danger exists for LGB youth when a counselor is unaware of her or his own personal prejudices.

The prospective counselor needs to know about myths and realities surrounding homosexuality, causal theories of sexual orientation, legal implications, the coming out process, attractions, experiences, self-identification, male and female experiential differences (such as the differing age of first same-sex sexual experience), significant relationship characteristics, disclosure to significant non-gays and the need to do so, positive identification as lesbian or gay, vulnerability of lesbian and gay adolescents at the point of disclosure, and high-risk sex and HIV transmission. Issues will differ with the individual, race or ethnicity, and the stage of sexual identification.

Teens need a welcoming person to listen to their stories in a nonjudgmental fashion. Professionals who are unaware of their own biases and prejudices may display pity or denial or perseverate on sexual orientation even when that is not a concern for the youth.

Advertise Your Availability

LGB students may be unwilling to initiate discussion, therefore, the prospective counselor must "advertise" availability. This can be accomplished by maintaining an attitude of openness toward, acceptance of, and support for diversity. A teacher or counselor can be supportive of minorities and express offense at humor based on stereotypes. Posters that celebrate diversity can be prominently displayed. Reading lists and hand-outs distributed to students can include some entries on sexual orientation and LGB issues. These actions will signal that a person is accepting of differences. Students also need to know that adults are approachable, some counselors display a pink triangle on their office walls with the word ALLY printed on it.

If all else fails, a counselor might approach students who seem to be experiencing personal difficulty. Students who are harassed can be invited for a chat. Obviously, reaching out to students in this way can be very risky unless a counselor is extremely careful and indirect. Direct confrontation can lead to denial. Sometimes, however, a student is just waiting to be asked. Open discussion of relationships and intimacy may signal a teen that it's okay to introduce sexuality.

Keep One Goal Foremost

Stated succinctly, the overall goal of counseling with LGB youth is to repair the consequences of biased socialization through corrective experiences. A counselor's task is to help teens decrease internalized homophobia before self-defeating patterns become ingrained.

Counseling should focus on facilitating social interactions with peers and family, understanding, and self-acceptance and on formation of a healthy and positive sexual-identity. Understanding is fostered by helping a youth gradually explore sexuality and self-awareness and the advantages and disadvantages of various life decisions. Self-acceptance and a healthy, positive sexual-identity are fostered by providing clarity and a sense of security, helping a teen avoid suppression and repression, and helping her or him cope with societal homophobia, shame, guilt, and self-contempt.

Set Tone at Onset

Counselors should be comforting and comfortable and provide a sense of security. Some youths may need help in establishing and clarifying their concerns. It is helpful to explore a teen's understanding of terms, such as homo, lezzie or dyke. Youth need to be able to see sexuality within the larger context of other interactions and concerns.

Avoid being cavalier. Phrases such as "it doesn't matter to me" convey that sexuality is of little difference, minimize a youth's struggle and feelings, and provide an "out" for a teen desirous of not confronting sexuality. Likewise, phrases such as "politically correct," "trendy," or "rebellious" also dismiss the youth's feeling.

The temptation to dismiss a youth's feelings as "a phase" must be resisted. While it may seem reassuring to say that same-sex attractions are temporary, it may create even more anxiety for a teen who feels otherwise.

Self-identification, which in the recent past usually occurred between the ages of 16-21 is occurring even earlier today.

An effective counselor is empathic and conveys an acceptance. It is important to remember that, most likely, the youth has internalized the negative attitudes of society and will be looking for signs of disapproval. Each counselor must be sensitive for internalization of negative attitudes and challenge assumptions and stereotypes about sexuality.

Individual needs will vary with the process of becoming a self-identified LGB person. Each teen needs to be reassured that it's okay to be lesbian, gay, or bisexual, or to be confused. Tentative exploration and questioning should be encouraged and supported. It is appropriate for a counselor to explore the way in which a teen decided that she or he is lesbian, gay, or bisexual. It is totally inappropriate for a counselor to question that decision.

Use Nonjudgmental Language

Any hint of discomfort by a counselor will be sensed immediately. This feeling should not be evident and the discussion should be nonjudgmental in nature. Language has power. It may be helpful for both the counselor and teen to practice saying the words "lesbian," "gay," and "bisexual" so the words do not sound strained. Being matter-of-fact will encourage openness, and the student will feel free to explore feelings and unique experiences without fear of evaluation.

It is best to make no assumptions about a youth's sexual orientation. A neutral stance may be beneficial until students disclose. Similarly, counselors can provide a rationale for the questions to be asked and let a teen know that no assumptions are being made.

On the other hand, questions that overlook sexual orientation imply a lack of concern or caring. Counselors can inquire about sexual orientation in a "permission-giving" manner. This type of question lets the student know that she or he is not alone and that it's acceptable to talk to the counselor about sexuality.

Use the Opportunity to Educate

By being factual and avoiding or correcting stereotypes, a counselor can provide clarity and perspective. Counselors can help a teen to clarify feelings, and identify and foster individual positive personality traits through knowledge. A youth needs to realize that sexual orientation is not a choice, a character flaw, or an illness.

Helping a youth distinguish between orientation, behavior and identity may be a first step toward positive self-identification. Sexual identity confusion may be explored by gentle, probing questions. This procedure can help to locate the cause of a teen's concern. It is important that a counselor be comfortable with the questions if honest answers and open discussion are desired. Probing questions might include topics such as self-perception and self-identity, amount of discomfort surrounding homophobic jokes and pressure to date the other gender or elation surrounding lesbians, gays, or bisexuals in the news, ability to separate myths and stereotypes from reality, degree of sexual arousal by both sexes, frequency of sexual activity with both sexes, intensity and length of same-sex relationships, future expectations and fantasies about relationships, and types of support systems available.

Helping professionals should create an environment that affirms a youth's identity and fosters identity integration. Integration is facilitated by helping each teen shape her or his own agenda based on individual needs and interests. The approach should be overwhelmingly affirmative.

A counselor can help a youth avoid premature self-labeling. Attempts at early labeling may actually be at variance with a teen's still emerging sexuality. Premature labeling superficially resolves identity questions but may increase anxiety. There is no need to accept even a self-label unless it fits and only if the owner wants to claim it. Each youth must determine her or his individual definition of that label. It's fine to wait and to explore one's sexuality slowly. But teens who have chosen to self-identify should not be automatically challenged. Some teens will not resolve their internal conflict and resolution may need to wait until they are more mature or more independent. Coping, decision-making, and communication skills can be addressed in counseling as future internal conflict resolution tools.

The counselor must also help each teen cope with homophobia and stigmatization. The youth may need to overcome victimization, explore and manage feelings of hurt and anger, or examine and identify efficient self-protection behaviors to deal with conflict, depression, and peer pressure.

Access to sexual-minority books in public and school libraries is helpful. Counselors can take a lead in ordering or recommending these books.

It may also be beneficial for a counselor to explore religious beliefs with a youth. Even if this issue is of little importance to a teen, it may be paramount for the family or become so.

Appreciate the Sexuality of Adolescents

Counselors should help youths explore their sexuality. The emphasis should be on feelings, emotions, attitudes, and behaviors, not labels. The orientation-behavior-identity paradigm may be helpful. Counselors can provide a rationale and framework for certain feelings, thoughts, and fantasies. It is good to remember that while a youth may discuss tolerantly the sexual orientation of others, she or he may be very intolerant of her or his own sexual orientation.

AIDS should be discussed openly and candidly with both male and female youths. Counselors and teens can discuss potential partners, their selection, and safe sex procedures. A youth must be impressed with the seriousness of the risk and of ways to reduce it.

Foster Coping and Self-Esteem

Teens need support and contact with others who care. A positive sense of self-worth and a positive attitude about sexual orientation are linked to good mental health, so it is important that counseling emphasize self-acceptance. The teen who prematurely identifies as lesbian, gay, or bisexual in a context with few positive role models may be searching for appropriate behaviors. The counselor who is lesbian, gay, or bisexual and open about sexual orientation can be especially important as a role model. The withdrawn teen needs the support of a caring professional as she or he learns to be more self-reliant and independent and to seek out peer support. In contrast, the angry teen can be helped to channel rage into self-affirming strategies. The most effective way to aid the development of self-esteem is to interact with the whole person. Youth resent being treated as "the problem" or as someone who needs to be helped or healed.

> ***LGB adolescents lack the societal support received by other teens.***

Prepare Youth for Coming Out

Coming out is a process in which an individual defines who she or he is, learns coping skills, and matures. The reaction of others can have important consequences. It is crucial, therefore, that other issues of self-identity, self-acceptance, and celebration are addressed prior to discussing coming out.

Although their struggle for independence is similar to that of other teens, LGB adolescents lack the societal support received by other teens. In order to be successful, an adolescent must possess a clarity based on self-esteem and self-awareness. Counselors and youths should remain mindful of this as they address issues such as motivation, when and to whom to disclose, possible reactions, options and supports, and the need for patience.

It is appropriate for a counselor to begin the coming out discussion by describing the possible ramifications and by examining with a youth her or his personal motivation. Honesty is not always the best policy, and each teen must weigh the consequences. Ultimately, a youth must be true to self. A healthy coming out is motivated by caring and by a desire to be open. However, coming out in order to strengthen one's own self-acceptance can be self-defeating. Self-acceptance should not be contingent on approval. A teen who is coming out must be operating from a position of strength.

A counselor can help teens realistically appraise the risks, including possible harassment and physical violence, alternative living arrangements, available support, future plans, and revision of the teen's plan. Role-playing can help a teen learn to come out while stressing the positive aspects of being lesbian, gay, or bisexual. It can put a youth in charge, changing the coming out process to a proactive experience. Potential scenarios and questions should be discussed and rehearsed.

Counselors can help a youth select to whom she or he will disclose to insure success. Before disclosure the counselor and youth can explore the options and the rationale for selecting certain individuals. There will be wide individual differences. Youths should not disclose to their parents unless they are secure with their sexual identity and possess a good relationship with that parent. Research has shown that coming out to one's parents while in high school can result in physical abuse and being thrown out of the home. Counselors working with youth should help them explore the pros and cons of coming out to their family. Counselors can help a teen appraise the family realistically and avoid self-blame for creating this "problem." Do parents, friends, and/or siblings want to know, or need to know, or are they asking, or actively avoiding the topic?

A youth can be helped in assessing and predicting the reactions of others. A rule of thumb is that the better the relationship, the better the reaction by the other person. Families that possess good communication skills and are loving, nurturing, and supportive should respond in kind. A family's or friend's overall attitude toward sexual-minorities is also an important factor in gauging their possible reaction. If unsure, a teen can introduce the topic into conversation in a general way. It may be best for a teen to proceed cautiously if a friend or sibling is very conforming or too immature, or a parent excessively demanding, intolerant, rigid, neglectful, status conscious, sexually repressive, or critical.

The when of coming out is equally important. Counselors can help teens identify the best times. In general, it is best to disclose in private when sufficient time exists for questions and discussion. When "outed" by others, a teen may find it very difficult to discuss her or his sexual orientation because the family may be very emotional or embarrassed and the teen may be unprepared to discuss the subject in a confrontative manner. A good counselor can help diffuse emotions and explore options by working with family members individually and collectively.

Negative responses may come in many forms. Some families will practice scapegoating in which homosexuality is blamed for all other family problems. In counseling, it is important to distinguish sexual orientation problems from family or parent-teen problems.

Most parents, friends, and siblings will not respond catastrophically. For most, there will be a reaction of shock or recognition followed by a period of adjustment during which most individuals will accept the new information either grudgingly or willfully.

Youth support groups are especially important when coming out. Each counselor should have a readily available resource list of such groups, along with supportive clergy, temporary "shelters," and phone and on-line services.

In some cases, it may be best to counsel patience. The odds against success may be too high. Patience may also be needed with parents and others who may need time to accept the new knowledge. A well prepared and self-assured youth can help others through the process and interact with others from a position of strength.

Coming out can be liberating. As the family members change their perceptions and begin to understand, they come to know a lesbian, gay, or bisexual teen better and to share more fully her or his life.

Pay Special Attention to Suicidal Youth

It is important in the initial session to establish a constructive relationship, to encourage a youth to express painful feelings, to discuss the precipitating event(s), to assess and evaluate the extent of impairment and the prognosis, to formulate an explanation of the factors that have prevented resolution of the problem, and to restore cognitive control by helping a youth interpret her or his response. It is important to avoid embarrassing the teen, shaming her or him, or blaming her or him for the current state of affairs. Sufficient time should be allotted for venting painful feelings and discussing the event that prompted the teen to seek help. Over time, a youth can gain control by understanding her or his response and can begin to identify alternative coping strategies.

Act as a Referral Source

It is appropriate to refer a teen to LGB organizations, such as youth groups, support groups, and groups with religious affiliations. In general, groups within the sexual-minority community do not focus on psychological adjustment specifically but offer a welcoming environment for self exploration.

Be an Advocate

Counselors can advise the school board on policy decisions, help effect curricular change, and educate faculty and staff on homosexuality and on LGB youths and their challenges. It is important that faculty training not focus on homosexuality or bisexuality as a "problem" but as a part of development. Mere tolerance is not sufficient; faculty must support and affirm LGB students. Counselors can let it be known that they do not tolerate homophobic remarks and can help faculty and students explore their fears about homosexuality and possibly reach an understanding and acceptance of LGB individuals.

Counseling Beyond the Individual Teen

It is appropriate and highly desirable at times to work with others in a youth's environment. These may include the family or a partner.

Work with the Family Unit

Family support is especially important for the self-esteem of LGB youth. However, parents and siblings should only be welcomed to participate at the invitation of the teen. Some parents may not be prepared to support their child, and parental homophobia must be assessed.

When a youth comes out, family and friends must yield their previously held expectations of heterosexuality. Those with whom a youth shares should feel honored that they are respected and trusted. Family responses will cover a range from shock, through denial, anger, resistance, and grieving, occasionally followed by guilt. Parents must deal with the dissonance between parental love and responsibility vs. societal values before arriving eventually at acceptance and restructuring of expectations.

Poor communication, parental grief and/or anger, and other unresolved family issues, religious beliefs, homophobia, misinformation, and/or stereotyping can create a difficult situation. Some parents have real fears for their child. This fear must be acknowledged, discussed and placed in perspective while the process of understanding and acceptance continues. Denial and nonacceptance can alienate a teen. Finally, most parents will panic at the mention of sexual behavior. If there is some precipitating sexual event, counselors do best not to focus on it. When the dust has settled, the "event" can be placed in perspective, although not dismissed.

Acceptance begins when parents begin to come out too. Support groups, such as Parents and Friends of Lesbians and Gays (PFLAG), can be helpful. Often, the best "cure" is for parents to meet LGB adults and other parents.

Help Couples Adjust
The loving relationships of LGB youth are no more inherently stable or unstable than those of heterosexual couples. On the other hand, the societal pressures on same-sex couples may be enormous. Such couples may also have less experience with relationships and be less socially mature. Youths may need some help to understand and to appreciate the effect of sex role socialization.

Conclusion

Research and clinical experience demonstrates that LGB youth benefit from two types of information. First, they need accurate and complete information on human sexuality. Second, they need to hear a consistent message of support and of their worth as an individual.

Sexual orientation is only one facet of personality. The constant condemnation and ridicule regarding sexual orientation can have a very negative effect on one's feelings of self-worth. Proud lesbian, gay, and bisexual youth, who have explored who they are and have come to a realization of the truly unique and wonderful individual they are, walk a little taller and speak a little more confidently. All they need to accomplish this transformation is the support of a knowledgeable professional who cares.

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This article is condensed from two chapters in Dr. Owens' book *Queer Kids: The Challenge and Promise for Lesbian, Gay, and Bisexual Youth*, 1998, Haworth Press: Binghamton, New York. It appears here with permission from the publisher.

Public Schools' Response to the Needs of Gay and Lesbian Youth

by Janet H. Fontaine, Ph.D.

Estimates by the American Friends Service Committee Gay/Lesbian Youth Program are that as many as nine students in every classroom of 30 are in some measure affected by homosexual issues (having a gay or lesbian parent, sibling, relative, or being gay oneself). My informal surveys of youth have confirmed this number. Yet even with this substantial number, the silence in our nation's schools concerning homosexuality remains. Breaking this silence is essential to the physical and mental well being of our gay and lesbian youth. Unfortunately, schools often succumb to broader community pressure and fear of controversy. This is exemplified by comments taken from a survey I conducted of school counselors' experiences with gay and lesbian students. Several counselors added comments that reflected their frustrations with their school systems and administrators unresponsiveness to the needs of gay and lesbian youth. These comments included:

> "…Administrators run for cover when the subject is brought up, as it illicits [sic] too much controversy. School counselors are attacked by religious fundamentalist groups for appearing to tolerate homosexuality when we promote guidance topics such as respecting differences…"

> "The school community is probably the biggest road block. The head of the PTA won't allow stories of families with homosexual parents read in the class. They feel it is wrong and we should teach that it is wrong…"

Whether through indifference, homophobia, or avoidance of controversy, schools have failed to acknowledge the existence of, and provide services for, their gay and lesbian students. This problem can be viewed as twofold—educational acts of omission and behavioral acts of commission.

During the Annual Conference of the Pennsylvania School Counselors' Association, I distributed 350 surveys. A total of 101 surveys were returned from 22 men and 79 women. The majority (96%) were European American. Over half (56%) were counselors at junior/senior high school, 43% were elementary school counselors. Both gender and school type distributions of respondents were representative of the overall PSCA membership statistics.

The Educational Problem

Curriculum
The topic of homosexuality in educational curricula is almost nonexistent. Currently, gay or lesbian students find little that even validates the existence of others like themselves. Examining course content would lead most students to believe that lesbians and gay men have never existed nor contributed to our nation. In my school counselor survey, only 14% indicated any inclusion of homosexuality in any courses in their schools.

The National Education Association's (NEA) *Training Handbook for Educators* included a Bill of Rights for Lesbian and Gay School Age Children that identified their right to "have access to accurate information about themselves, free of negative judgment, and delivered by trained adults who not only inform them, but affirm them."

Whether through indifference, homophobia, or avoidance of controversy, schools have failed to acknowledge the existence of, and provide services for, their gay and lesbian students.

The handbook encouraged teachers to include the contributions of gays and lesbians throughout the curriculum. While acknowledging that some courses lend themselves more easily to these discussions, teachers of other subjects were encouraged to explore the historical contributions of lesbians and gay men and recognize role models.

The open acknowledgment of gays and lesbians in course content can begin to demythologize the topic. Educational efforts that provide accurate information increase understanding and diminish prejudice and stereotypes. Developing inclusive course materials helps create an atmosphere that legitimizes, facilitates, and promotes the discussion of this topic and creates an environment that is more tolerant. For students struggling with a socially stigmatized sexual identity, the inclusion of such information can lend hope and relief by providing role models and evidence that others before them have survived and become contributing members of society. At a point in their identity development when gay and lesbian adolescents are struggling to integrate a negatively stigmatized sexual identity, providing such information could be invaluable to the formation of a more positive self-concept.

Educational Resources

Resource materials for both faculty and students to learn more about homosexuality are nonexistent in most school libraries and media centers, further isolating the educational community and gay/lesbian youth from information that could lend understanding and comfort. Books, pamphlets, videos, and other materials should be available for both.

The Behavioral Problem

Attitudes

Students perceive teacher attitudes and feelings through the teacher's verbal and nonverbal behavior. Teacher attitudes can provide the validation for a gay student's self-acceptance or self-rejection. While educators are uniquely poised to play a primary role in the lives of adolescents, evidence indicates that their use of this role has been less than positive for sexual minority students. In research by Telljohann and Price, only 20% of gay and lesbian students were able to identify someone in their school who had been supportive to them. Other research has reported that 80% of pre-service teachers harbored negative feelings and attitudes toward gays and lesbians while nearly two-thirds of school counselors expressed similar feelings.

In my survey, school counselors were asked to determine current attitudes of students, faculty, and administrators toward gay and lesbian students in their schools. Results reflected more intolerant attitudes toward gay/lesbian students than supportive ones. Using a 5-point scale (1 = intolerant; 5 = supportive), administrators were seen as the least intolerant (average 2.74) and students as the most intolerant (average 2.08). This latter finding—that students harbor the greatest degree of intolerance toward fellow gay and lesbian students—is supported by previous research and the many stories of abuse told by gay and lesbian youth themselves.

Recently, media images and the popular press have provided more positive images of gays and lesbians, so it is conceivable that attitudes have become more tolerant. Unfortunately, my research did not support this. Counselors' perceived attitude changes of students, faculty, and administrators over the past 10 years were assessed using a 5-point scale (1 = less tolerant, 3 = no change, 5 = more tolerant). Rating averages reflected little to no change in any of the groups (students = 3.13; faculty = 3.19; administrators = 3.24). Even with increased media visibility and the efforts of professional organizations that encourage tolerance and inclusiveness (National Association of School Psychologists, NEA, American School Health Association), little change has been effected in the daily implementation of educational programming and in individual educators' attitudes.

Currently, gay or lesbian students find little that even validates the existence of others like themselves.

These attitudes are apparent through comments of two school counselors taken from this study:

> "Gay/lesbian [sic] turn me off based on my own beliefs/prejudices. I find this morally reprehensible yet as a counselor I am morally bound to help such a student. If a youngster approaches me, only then will I do what I must do, to inform myself, not be judgmental, and to offer appropriate counseling."

> "I believe that our society tends to take the illness in society and accept that illness rather then [sic] try to cure the illness. Please do not take me wrong. I hate the sin but I love the person. I just feel that if a person is ill, one trys [sic] to cure the illness not accept it and even promote it in society by telling the person the act and life style is 'ok.'"

These attitudes cannot help but be reflected in the counseling provided any gay, lesbian or questioning student. Direct approaches to changing attitudes toward gays and lesbians through educational programming have proven more successful. The *Affording Equal Opportunity to Gay and Lesbian Students Through Teaching and Counseling: A Training Handbook for Educators*, is the NEA's recognition of such and acknowledgment that attitude change is crucial to the creation of safe and supportive school environments. The Handbook encourages school districts to provide training for staff, school board members, parents, and other community-based groups in order to facilitate a better understanding of the problems that gay and lesbian youth face.

Inappropriate Behavior

The problem of verbal and physical abuse of gay and lesbian students in their schools is one of significant proportions. In one study, 45% of gay males and 20% of lesbians experienced physical or verbal assault in high school. Additionally, 28% of these students felt forced to drop out of school because of harassment based on their sexual orientation. In my survey of school counselors, 59% had observed incidents of student harassment of gay/lesbian students. One counselor noted that he knew of one male student who had quit school because of continuous homophobic comments made to him.

Such inappropriate behaviors are more easily regulated than attitudes, and schools have the responsibility to do so. School regulations and policies are the most common means of addressing discriminatory behaviors. Active enforcement of such policies is also necessary.

Anti-discrimination policies exist in a number of schools. However, many policies are designed to address racial discrimination and infrequently extend such protection to sexual minorities. Inclusive school policies need to be established that foster the norm that the dignity and rights of all students will be respected. Schools that do not actively provide for the protection of minority group members lend implicit support to their continued harassment. The NEA recommends school districts establish policies that recognize the rights of all students to:

- attend school free of verbal and physical harassment,
- attend schools where respect and dignity for all is standard,
- be included in all support programs that exist to help teenagers deal with the difficulties of adolescence,
- attend schools where education, not survival, is the priority,
- have a heritage free of crippling self-hate and unchallenged discrimination.

No Longer a Matter of Choice

The *voluntary compliance* of implementing an inclusive curriculum and providing a supportive environment for gay and lesbian students may be a luxury of the past. Much like the civil rights movement, it appears the cause for equal rights for gay/lesbian students in public schools is turning to the legal system to expedite its quest. A recent Wisconsin case may serve as the benchmark for what, undoubtedly, will sensitize school boards, administrators, and educators across the country to their responsibility to protect all youth in their schools, not just the heterosexual ones. In the case, the plaintiff, Jamie Nabozny, was awarded $1 million in damages for the treatment he endured while a gay student in his public school system. The suit cited continuing instances of physical abuse and verbal harassment for which school administrators took no action and were thus found liable for violating Nabozny's rights.

Conclusion

Due to the lack of recognized healthy role models, support systems, and affirmation of who they are within their school system, gay and lesbian youth have little basis for developing feelings of self-worth and positive aspirations for their future. When educators fail to challenge homophobic remarks and establish and enforce anti-discrimination policies inclusive of sexual minority youth, they collude in the emotional and physical abuse of every adolescent in the school. The Nabozny case may serve as impetus for school districts to more actively support the rights of all youth or risk litigation. Comments cited here, however, indicate that successful implementation of such changes will take more than the mere creation of policy.

Janet H. Fontaine, Ph.D. is Associate Professor, Department of Counseling, Indiana University of Pennsylvania, Indiana.

This article is condensed from J.H. Fontaine, (1997). The Sound of Silence: Public School Response to the Needs of Gay and Lesbian Youth. Co-published simultaneously in *Journal of Gay & Lesbian Social Service*, 7(4), 101-109; and *School Experiences of Gay and Lesbian Youth: The Invisible Minority*, (Mary B. Harris, Ed.) pp. 101-109, The Haworth Press. It appears here with permission from the publisher.

Resources

American Psychological Association (APA)
www.apa.org

The APA provides many pages about lesbian, gay and bisexual people, including youth. A query in their search engine will bring up such valuable resources as: "Answers to Your Questions About Sexual Orientation and Homosexuality" at www.apa.org/pubinfo/answers.html; and "Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients" at www.apa.org/pi/lgbc/guidelines.html.

Gay, Lesbian, and Straight Education Network (GLSEN)
www.glsen.org 212-727-0135

According to their Web site, "GLSEN strives to assure that each member of every school community is valued and respected, regardless of sexual orientation or gender identity." The GLSEN "library" is full of information for school personnel, including reference materials, "school tools" and "community tools," resources for teachers, and a number of resources about athletes. GLSEN's newsletter, *Respect*, links to other resources, and information about local GLSEN chapters are also online.

Parents, Family and Friends of Lesbians and Gays (PFLAG)
www.pflag.org 202-467-8180

PFLAG is a great referral for parents of LGB youth. The National PFLAG site includes a listing (and links where available) for local chapters. PFLAG also includes a variety of on-line booklets and resources, including "Focus on Safe Schools," "Tips for Professionals Working with Gay & Lesbian Youth," and "Our Daughters and Sons: Questions and Answers for Parents of Lesbian, Gay and Bisexual People."

Safe Schools Coalition of Washington
www.safeschools-wa.org

The Safe Schools Coalition's mission "is to help make Washington State schools safe places where every family can belong, where every educator can teach, and where every child can learn, regardless of gender identity or sexual orientation." This site contains some excellent resources including a table discussing the differences between "affirming" and "promoting," and two wonderful documents titled "If These Were Racial Slurs, Teachers Would Be Stopping Them," and "They Don't Even Know Me: Understanding Anti-Gay Harassment and Violence in Schools." Despite its name, this is a good resource for all school personnel.

Youth Resource
www.youthresource.com

A project of Advocates for Youth, Youth Resource is a Web site for lesbian, gay, bisexual and transgendered youth. This site includes a number of resources including a database of youth organizations, and "Ask Caitlin," a confidential opportunity for youth to ask questions of a social worker, researcher and author (including two articles in this issue of *The Prevention Researcher*). This site also includes a special section for a variety of communities, including youth of color, bisexual youth, young women, and young men. Each of the "communities" includes articles, book reviews, and links to other web resources.

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Addictions Services Barriers for LGB Youth

by Robb Travers, Ph.D. (candidate) and Margaret Schneider, Ph.D.

The impact of homophobia and heterosexism on the well-being of lesbians and gay men has been well documented. Yet it is not clear that helping professionals appreciate the impact of this stress when responding to the needs of clients. As part of a larger study, interviews were conducted with 17 lesbian and gay youth who described their experiences with addictions services. Regardless of the intentions of the professionals offering the services, it is the experiences and perceptions of the clients that influence whether or not lesbian, gay and bisexual (LGB) youth will access services and benefit from them. We are not suggesting that all professionals behaved in negative ways or that all services were unsuitable. In fact, most providers we interviewed were well-meaning and wanted high-quality service for their LGB clients. However, there are attitudes, beliefs, and behaviors that are counterproductive and/or destructive for LGB youth.

Marginalization. The youth felt marginalized, silenced, or invisible in a variety of circumstances. In some instances, clients were assumed to be heterosexual; the possibility that some were not seemed not to occur to counselors. In other instances, staff told youth that their sexual orientation issues were unrelated to their addictions, even though the youth clearly stated that their substance use was precipitated by stressors associated with being lesbian or gay. This disregard for sexual orientation issues often resulted in inappropriate treatment models. In particular, the 12-step programs with religious overtones were not productive to youth who viewed organized religion as one of the sources of their stigma.

Sexual Orientation as the Focus. At the other extreme, there were times when sexual orientation was given an inordinate amount of attention. Some counselors "outed" LGB clients for ostensibly therapeutic reasons. Not only did this breach confidentiality, but it also compromised the clients' safety. Even though sexual orientation was frequently ignored as a counseling issue, participants reported recurrent incidents of anti-lesbian or anti-gay harassment, including physical threats, from other clients and even staff. These threats were intensified in residential programs. Additionally, the staff's response to such harassment was inadequate.

The staff's discomfort with LGB clients sometimes manifested in the withholding of services. In some cases, staff suggested that LGB clients did not belong in their program, they failed to extend services to LGB clients, or they actively encouraged clients to discharge themselves before the youth felt ready. Some youth believed staff became distant after disclosure and the frequency or duration of sessions sometimes decreased.

Lack of Accurate Information. Lesbian and gay youth encountered staff with little accurate information about homosexuality. Staff had no information about community supports such as AA groups for lesbians and gay males. Some staff subscribed to common myths and stereotypes, for example, that homosexuality is caused by sexual abuse, or that the youth could become heterosexual through therapy.

Effective Strategies

To provide LGB youth with effective addictions services, a number of strategies must be put in place to improve actual service delivery and/or to enhance the perception that the services are accessible and suitable for LGB youth. A lesbian/gay positive therapeutic milieu must be created, not only by eliminating heterosexist and homophobic assumptions, but also by providing a concrete LGB presence. This can be accomplished by (a) having information about LGB community resources visible and accessible, (b) doing outreach in LGB communities, (c) revising the institution's mandate to include statements about services to LGB clients, and (d) including "out" lesbians and gay men on the staff and board of directors.

Services need to develop clear nondiscrimination policy statements and offer periodic workshops to ensure that new board and staff members are fully informed of the organization's position. Staff must be required to attend training sessions to develop their knowledge of, and sensitivity to, gay and lesbian issues; to develop their skills in working with this population; and to become aware of their own attitudes and beliefs that influence their work with LGB clients.

This article is condensed from R. Travers and M. Schneider (1996). Barriers to Accessibility for Lesbian and Gay Youth Needing Addictions Services. *Youth & Society*, Vol 27(3), pp, 356-378. Copyright © 1996 by Sage Publications. Reprinted with permission of Sage Publications, Inc.

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Youth Smoking Prevention: What Works?

By Paula M. Lantz, Ph.D., Peter D. Jacobson, J.D., M.P.H., and Kenneth E. Warner, Ph.D.

A large body of research shows that very few people in the United States initiate smoking or become habitual smokers after their teen years. At the present time, nearly 9 out of 10 current adult smokers (89%) started their habit before age 19. Although many tobacco prevention activities have focused on youth, smoking among U.S. adolescents actually rose throughout most of the 1990s, until declining somewhat in the past few years.

Given the epidemiology of smoking initiation, a great deal of policy and programmatic attention has been directed at youth smoking in the United States. In this article, we synthesize the burgeoning literature regarding efforts to discourage youth from smoking. For those areas in which there is empirical evidence from evaluations and other research studies, we summarize the state of the science regarding the impact or effectiveness of these general strategies. In addition, we also comment on emerging initiatives and interventions that have not yet been evaluated or have not received much attention in the peer-reviewed literature in an attempt to identify emerging trends and promising innovations.

School-Based Educational Interventions

A large number of school-based programs have been implemented during the past three decades. Most of these efforts target elementary school and/or middle school students. As described in a 1994 Institute of Medicine report, the majority of these programs have tended to be based on one of three main approaches. The first approach is an *information deficit* or *rational model* in which the program provides information about the health risks and negative consequences of tobacco, most often in a manner intended to arouse concern or fear. The primary premise of this approach is that youth are generally misinformed about the risks of smoking and that educating them about the health and social detriments of smoking will provide a deterrent.

The second major educational approach to youth tobacco prevention is an *affective education model* in which the program attempts to influence beliefs, attitudes, intentions, and norms related to tobacco use with a focus on enhancing self-esteem and values clarification. This type of program emphasizes initiation influences within an individual, recognizing that knowledge deficits are not the only factors associated with smoking initiation.

The third approach to tobacco prevention is based on a *social influence resistance model,* which emphasizes the social environment as a critical factor in tobacco use. In addition to individual factors, influences outside of an individual, such as peer behavior or attitudes, and certain aspects of the environmental, familial, and cultural contexts, are considered to be of great importance. As such, this type of intervention focuses on building skills needed to recognize and resist negative influences, including recognition of advertising tactics and peer influences, communication and decision-making skills, and assertiveness.

> ***Nearly 9 out of 10 current adult smokers (89%) started their habit before age 19.***

The results of several individual evaluations and meta-analyses strongly suggest that educational programs based on the social influence resistance model are the most effective of the three approaches. Several individual studies and meta-analyses suggest that programs that incorporate a social influences model and focus on skills in recognizing and resisting social pressures have a modest but significant impact on both smoking initiation and level of use. Even so, the long-term impact of school-based educational interventions is of concern. It appears that the effects tend to dissipate with time, with effects generally persisting in the range of one to four years. Program "boosters" or subsequent interventions appear to enhance the staying power of the intervention effects, although the most appropriate content of and timing for these booster sessions is not known.

Community Interventions

The increased understanding of the combined effects of environmental, social, and cultural conditions on tobacco use has resulted in an emphasis on interventions that include comprehensive, community-based approaches. Such an approach targets multiple systems, institutions, or channels simultaneously, and employs multiple strategies. In general, community interventions have multiple components, and involve the use of community resources to influence both

(Continued on Page 3)

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From the Editor's PC

Dear Colleague,

I welcome you to Volume 8(2) of *The Prevention Researcher.* This issue focuses on an important public health concern; one that gets a lot of attention but not enough prevention and intervention—teenage tobacco use.

This issue begins with an excellent overview of the multitude of prevention strategies which have attempted to discourage youth from smoking. Authors Paula M. Lantz, Ph.D., Peter D. Jacobson, J.D, M.P.H., and Kenneth E. Warner, Ph.D. of the University of Michigan School of Public Health not only summarize the state of the science regarding prevention strategies but also comment on emerging trends.

This article is followed with an examination of the social influences which entice a youth to transition from non-smoking and experimental smoking to regular smoking. Authors Min Qi Wang, Ph.D. and James M. Eddy, D.Ed. of the University of Alabama, and Eugene C. Fitzhugh, Ph.D. of the Knox County Health Department, in Tennessee, examine this transition using the social influence model.

Not all tobacco use is limited to smoking. Margaret M. Walsh, Dr.PH, James Ellison, Ph.D., Joan F. Hilton, Sc.D., Virginia L. Ernster, Ph.D. and Margaret A. Chesney, Ph.D. from the University of California San Francisco discuss the use of spit (smokeless) tobacco among high school baseball athletes. Jennifer A. Epstein, Ph.D., Kenneth W. Griffin, Ph.D., M.P.H., and Gilbert J. Botvin, Ph.D. of Cornell University Medical College follow with a look at competence skills and how these can be used to deter smoking among inner city adolescents.

And, finally, because many youth do become smokers, we look at school-based cessation programs. Debbie Coleman-Wallace, Dr.PH, and Dongqing Terry Wang, M.S.P.H., of the Rollins School of Public Health, Emory University, and Jerry W. Lee, Ph.D., Susanne Montgomery, Ph.D., and Glen Blix, Dr.PH, at the School of Public Health at Loma Linda University evaluate both the Tobacco Education Group (TEG) and Tobacco Awareness Program (TAP).

We are most appreciative of the efforts of all our authors. And finally, we would like to remind all our readers that references for all articles which appear in *The Prevention Researcher* are available on our Web site or by request from our office.

Have a great summer,

Steven Ungerleider, Ph.D.
Psychologist/Editor, *The Prevention Researcher*

***The Prevention Researcher* is indexed in ERIC, SocAbstracts, and CINAHL.**

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Recycled Paper

Youth Smoking Prevention: What Works?

(Continued From Page 1)

individual behavior and community norms or practices related to adolescent tobacco use. This includes the involvement of families, schools, community organizations, churches, businesses, the media, social service and health agencies, government, and law enforcement, with intervention strategies generally focused on making changes in both the environment and individual behavior.

Although community interventions take a variety of shapes, common elements among them include a shared emphasis on altering the social environment or social context in which tobacco products are obtained and used, and a shared goal of creating a social environment that is supportive of non-smoking and cessation. Some of the components of community interventions, such as mass media campaigns and youth access restrictions, are also implemented as stand-alone interventions, as described below.

While an increasing number of communities are attempting to influence youth tobacco use with multiple-component interventions, there are few published reports of evaluations with rigorous designs. The available research results, however, are encouraging in many cases. For example, a community intervention involving mass media, school-based education, parent education, community organizing, and policy advocacy in 15 communities in the Kansas City area was found to be effective in reducing tobacco, alcohol, and illicit drug use. Regarding tobacco use two years past the start of the intervention, the rate of smoking in the last month among youth was reported to be 19% in the intervention communities versus 29% in the control communities.

School-based programs and community interventions involving parents, mass media, and community organizations appear to have a stronger impact over time when they work in tandem rather than as separate, stand-alone interventions. Mobilizing parents and community elements outside of the school (including the media) is seen as enhancing school-based interventions and increasing the potential for a lasting behavioral impact.

Although the results of a small number of controlled trials of community interventions attest to their ability to have an effect on youth smoking behavior, it is likely that broad-based community interventions alone are not sufficient to bring about a substantial and sustained decline in youth smoking. Community efforts, as symbolized by COMMIT, ASSIST, and other community interventions, likely need to be combined with stronger advocacy, taxation, media interventions, and policy formation and implementation, as discussed below.

Recently, several state health departments (including those in California, Massachusetts, and Florida) have implemented comprehensive tobacco prevention and control programs that attempt to tackle youth tobacco using multiple interventions aimed at a number of different levels. Each of these programs targets several populations concurrently, and uses multiple channels to disseminate the message. These programs are comprehensive both in using a variety of strategies to reach their audiences, in incorporating multiple types of intervention (i.e., education, incentives, and regulation) at the state, regional and local levels, and attempting to have a strong policy component. "Best practices" for this type of comprehensive tobacco control program were recently summarized by the Centers for Disease Control and Prevention. While these programs are in the early stages of development and implementation in many states, early results suggest that these comprehensive models have significant potential for youth tobacco control. Early lessons drawn from state experiences are that more comprehensive, aggressive, and better funded state programs will lead to greater reductions in tobacco use than less intense efforts. In short, a state's commitment to the program's intensity and comprehensiveness matters.

Mass Media/Public Education

Mass media strategies have been used for broad-based public education regarding a variety of public health issues, including tobacco use prevention and control. Mass media efforts are viewed as particularly appropriate for reaching youth, who are often heavily exposed to and greatly interested in media messages. Youth have been the primary target of some hard-hitting and sophisticated anti-tobacco media campaigns in several communities and states, including California, Florida, and Massachusetts as a major part of their comprehensive tobacco control programs. In addition, the American Legacy Foundation (the independent foundation established as part of the multi-state settlement with the tobacco industry) has launched a large and aggressive anti-tobacco media campaign aimed at youth. Despite some encouraging information from Florida regarding a sharp decline in youth smoking, the impact of anti-tobacco media campaigns on smoking behavior among youth in general or specific subgroups is unknown. The few existing studies of the impact of mass media campaigns on youth smoking have shown varying results.

> ***The impact of anti-tobacco media campaigns on smoking behavior among youth in general or specific subgroups is unknown.***

Media campaigns that involve essential elements of social marketing and are theoretically driven may well have an effect on the attitudes and behaviors of youth regarding tobacco use, although the impact of such campaigns is challenging to evaluate and has not yet been demonstrated. The literature suggests that mass media interventions increase their chance of having an impact if the following conditions are met:

1) the campaign strategies are based on sound social marketing principles;
2) the effort is large and intense enough;
3) target groups are carefully differentiated;
4) messages for specific target groups resonate with "core values" of the group (rather than simply preach about the health risks of tobacco use), and are based on empirical findings regarding the needs and interests of the group; and
5) the campaign is of sufficient duration.

Tobacco Advertising Restrictions

Cigarettes are a heavily advertised and marketed consumer product. There is great concern that tobacco advertising and marketing—including the distribution of promotional products such as clothing, sporting equipment, and gear for outdoor activities—are positively associated with youth smoking. A growing amount of research evidence suggests that youth awareness of tobacco marketing campaigns, receipt of free tobacco samples, and receipt of direct mail promotional paraphernalia are associated with smoking susceptibility and initiation.

The technical limitations of econometric approaches to estimating the effects of advertising on cigarette consumption, combined with a lack of studies on adolescent smoking make this literature of little use in trying to assess whether advertising affects smoking by adolescents.

Similarly, the potential effect of cigarette advertising restrictions or bans on adolescent smoking behavior also is unclear. Some states and municipalities have implemented restrictions regarding tobacco advertising. These types of bans are too new to have been evaluated yet, and the implementation of similar bans nationwide has been delayed because of legal challenges. Researchers, however, have concluded that total bans on tobacco advertising would likely have a greater impact than partial bans, because partial bans afford tobacco companies the opportunity to switch advertising expenditures to other promotional media and methods.

Youth Access Restrictions

In the past decade, the issue of youth access to tobacco products has received an explosion of attention. Policy action has been seen in a number of areas, including regulation of sellers, regulation of buyers, restrictions on the distribution of free products or samples (including coupons), and regulation of the means of tobacco sale (where and how it can be sold). The latter includes state and local efforts to restrict or totally ban tobacco sales via vending machines.

Federal Public Law 102-321, commonly referred to as the Synar amendment and enacted in 1991, stipulates that states must enforce laws restricting the sale and distribution of tobacco products to minors and must demonstrate success in reducing youth tobacco access or risk not receiving the full complement of block grant funding for the treatment and prevention of substance abuse. Although the Synar amendment has led to a number of developments in youth tobacco control, it is believed that few jurisdictions seriously enforce laws regarding the sale of tobacco to minors. This is important, because while laws regarding sales to minors appear to be rather benign in and of themselves, what seems to make a difference regarding illegal tobacco sales to minors is whether or not the laws are enforced.

Several controlled community intervention studies have demonstrated that increased enforcement of tobacco-sales laws can reduce illegal sales to minors. Unfortunately, however, the evidence that a reduction in sales actually translates into a reduction in tobacco consumption is limited. Several studies failed to look at the impact of enforcement interventions on smoking behavior. In studies that looked at both sales and behavior, the two did not always go hand in hand.

If the only or primary way in which youth gain access to cigarettes is through illegal sales, then we might expect the enforcement of youth access laws to have a powerful effect on smoking behavior. However, youth cite a number of "social sources" (such as family, friends, or even strangers) for their cigarettes as well as illegal purchase. Thus, what can be said with the evidence at hand is that youth access interventions can lead to a general reduction in illegal sales of cigarettes to minors. Whether this will translate into reduced and sustained reductions in youth tobacco use remains to be seen.

Tobacco Excise Taxes

Tobacco products are taxed by the federal government, states, and a few local governments. While generating revenue, tobacco taxation is also a policy that creates an economic disincentive to use tobacco. Theoretically, increasing the price of cigarettes through taxation could reduce adolescent cigarette consumption through three mechanisms:

1) some adolescents would quit smoking;
2) some would reduce the amount that they smoke; and
3) some would not start smoking in the first place.

The extent to which higher cigarette taxes will achieve these objectives depends upon how responsive smokers, and prospective smokers, are to price increases.

Studies of the elasticity of demand for cigarettes have followed a long tradition, dating back more than half a century. Most of these studies have focused on the adult or overall demand for cigarettes, with comparatively few focused on teenage cigarette demand. In regard to youth, the evidence on the degree to which teenagers are responsive to changes in cigarette prices is mixed, but the general consensus is that higher prices are an effective deterrent to youth smoking. That is, increasing the price of cigarettes leads to lower consumption by both adults and teenagers. Because cigarette price increases have been relatively small (i.e., under a dollar and, in many cases, just a few cents), it is difficult to predict with confidence the impact that a large price increase—such as a dollar or more per pack— would have on teenage cigarette consumption. The effects might be expected to be proportionately greater than those of a small tax increase.

> ***What seems to make a difference regarding illegal tobacco sales to minors is whether or not the laws are enforced.***

Recent Innovations

The purpose of this section is to identify emerging trends and promising innovations in policy and programmatic responses to youth smoking. The majority of strategies described below have received no or only cursory evaluations. Thus, while some of these approaches may be compelling or appear to have promise, there is little to no empirical evidence to support claims about their worth or effectiveness at this time.

Smoking Cessation Interventions

The results of a number of descriptive studies and focus group studies suggest that many teen smokers are motivated to quit smoking. The impact of smoking cessation interventions among adolescents, however, is not well understood. None of the nicotine replacement therapies currently on the market have been approved for subjects under the age of 18. In addition, until very recently, formal smoking cessation programs were aimed exclusively at adults. An important recent trend, however, is an increase in the number of such smoking cessation programs now available for youth. Given the cost-effectiveness of smoking cessation interventions for adults, and the large number of addicted teenagers, research on cessation programs tailored to youth is an important area and should be a high priority.

Computer-Based Systems

An important emerging trend is the use of computer-based systems to communicate messages about tobacco to teens. Some of these innovations have been evaluated, but because most are in various stages of development and implementation we consider them under the category of new innovations. The advantages of these efforts, if successful, are their low cost and adolescent receptivity to computer-based information.

Peer-Based Interventions

A major trend in school-based interventions is the use of peer-education programs, such as Teens Against Tobacco Use. These programs train older students to become positive role models for middle and elementary school students. Many of these programs include a media literacy component through which teens learn how the tobacco industry's advertising savvy has manipulated and distorted information about tobacco.

Penalties for Possession and Use

A controversial response to youth tobacco use that has emerged is the increasing willingness of state and municipal policymakers to fine underage youth for using tobacco products. Tobacco control advocates have vociferously protested this approach as an attempt to shift attention away from vendors who sell tobacco products to minors. Regardless, this shift appears to be gaining momentum. Minors caught smoking or in possession of cigarettes can face a variety of penalties, ranging from a ticket or fine to suspension from school, denial of a driver's license, or any combination of these responses. Fines can also be combined with tobacco education or cessation classes. An additional important innovation to watch for in this area is the use of teen smoking courts.

School Policies

Schools may have their own smoking policies, which can apply even to those students over 18 years old. Penalties for violations include fines, smoking education and cessation classes, informing the student's parents, and suspension and/or expulsion. It appears that schools are increasingly willing to develop, implement, and enforce no-smoking policies. Recent school smoking policies seem to use a combination of punishments, rather than just fining or suspending students.

Restrictions on the Sale and Marketing of Tobacco Products

One way to restrict youth access to tobacco products is to physically remove the products from areas where youth can go. For example, recent restrictions on vending machines have been effective in removing them as a source of cigarettes for minors. In addition, the issue of billboard tobacco advertising was addressed in the 46-state settlement with the tobacco industry, which stipulated the removal of billboard advertisements by April 23, 1999. An emerging trend is to restrict self-service displays of cigarettes.

Direct Restrictions on Smoking

Policy efforts to restrict public smoking have proliferated since the 1980s. Such efforts include state and local restrictions on smoking in public facilities, outdoor spaces, worksites, hospitals, restaurants, bars, hotels, and on airline flights. Some econometric studies of teenage and young adult smoking behavior have found evidence that clean indoor air laws reduce teenage cigarette consumption. Although the reasons why such laws may be effective in reducing youth smoking are unknown, one could speculate that they simply reduce the opportunities available for smoking. Alternatively, or perhaps in conjunction with these reduced opportunities, clean indoor air laws may be a useful vehicle for creating a cultural norm that suggests smoking is socially unacceptable.

Interventions that Focus on Adolescent Risk Taking

Youth smoking occurs in a web of social relations that fosters many types of adolescent experimentation and that also may foster problem behaviors. Because of this social context, youth smoking arises from some of the same family, peer, and community influences that are also important to sexual risk-taking, crime and violence, and the initiation of harmful alcohol and illicit substance use. Existing prevention research regarding other adolescent problem behaviors therefore has potentially important implications for the design and evaluation of programs to curb youth smoking. Such interventions for older adolescents are often focused on improving academic skills. Many are also aimed at creating a sustained relationship with adult advisors or mentors who can provide social and emotional support while reinforcing appropriate social norms regarding substance abuse and other behaviors. An additional approach involves "family-focused" interventions.

> ***There is no "magic bullet" in terms of youth tobacco control on the horizon… However, our review suggests a number of prevention strategies that are promising.***

Discussion

The most obvious conclusion from this review is that adolescent smoking prevention efforts have had mixed results, and that there is no "magic bullet" in terms of youth tobacco control on the horizon. As a result, advocating for a focus on youth smoking prevention and control is somewhat controversial. Some policy analysts have suggested that the focus of public policy should be to reduce teenage smoking initiation rates. Others have suggested that the focus on children will undermine the broader and likely more fruitful initiatives and programs needed to attack smoking and to promote cessation among adult habitual smokers.

From a practical perspective, these different policy views are not mutually exclusive. Both can be implemented simultaneously, and should be considered as complementary rather than competing strategies. From a public health perspective, we are appropriately concerned that the prevalence of youth smoking remains high despite the amount of resources already devoted to this problem and the wide array of interventions that have been tried. Yet, it is possible that without these interventions, rates of both experimental and habitual smoking among youth would be even higher.

Our review suggests a number of prevention strategies that are promising, especially if conducted in a coordinated way to take advantage of potential synergies across interventions. This includes such intervention strategies as media campaigns, teen cessation programs, community interventions that change the social context of smoking, and tobacco excise tax increases. Equally as important, there is great potential for these interventions to be cost-effective. Even modest gains from prevention and cessation efforts could lead to substantial reductions in the morbidity and mortality costs of smoking. We believe that previous calls for tobacco control efforts that are "youth centered" remain relevant and critically important as we move into the 21st century.

This review suggests that there are a number of interventions and strategies that deserve further consideration, dissemination, and evaluation. The resources available through the settlement with the tobacco industry provide an unprecedented opportunity to invest in youth tobacco control. Thus, we strongly advocate that this opportunity be seized and that significant state resources—along with other resources—be devoted to expanding, improving and evaluating tobacco prevention and control activities among youth.

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This article was abstracted from P.M. Lantz, P.D. Jacobson, K.E. Warner, J. Wasserman, H.A. Pollack, J. Berson, and A. Ahlstrom (2000). Investing in Youth Tobacco Control: A Review of Smoking Prevention and Control Strategies. *Tobacco Control,* 9, 47-63. It appears here with permission from the publisher.

Social Influences on Adolescents' Smoking Progress

By Min Qi Wang, Ph.D., Eugene C. Fitzhugh, Ph.D., and James M. Eddy, D.Ed.

Despite a recent report that smoking prevalence has slightly declined among high school students, the prevalence of cigarette smoking among this population remains high. Literature has indicated that any smoking by an adolescent, including experimental smoking, dramatically increases the risk of that adolescent becoming a regular adult smoker.

In relationship to becoming a regular smoker, cigarette smoking behavior follows a complex developmental process. Dr. Brian Flay and colleagues have identified a model to explain the smoking acquisition process which is composed of 5 distinct behavioral stages:

1) the preparation stage (never smoked);
2) the initiation stage (trying the first cigarette);
3) the experimentation stage (repeatedly trying cigarettes);
4) the habituation stage (becoming a regular smoker); and
5) the maintenance stage (addictive smoking).

Though this smoking acquisition process usually proceeds from one stage to the next, adolescents may remain in the same stage, or move back to previous stages once they have initiated smoking. To incorporate the most effective strategies for smoking prevention/intervention programs, it is important for smoking prevention practitioners (such as school health education teachers) to understand those factors which differentiate those adolescents who are likely to proceed to regular smoking from those who are likely to maintain non-smoking status. Furthermore, the stage model of smoking indicates that smoking interventions targeting the adolescent at the preparation and experimentation stage are more effective than interventions targeting more advanced stages (habituation and maintenance) when smoking has become a confirmed addictive behavior.

Limited information is available about the processes and factors involved in the transition from non-smoking and experimental smoking towards becoming a regular smoker using the social influence model, especially with a national representative sample. The purpose of this study was to examine the social factors that may influence adolescent smoking acquisition over a 3-year period.

Methods

We examined 6,519 adolescents who participated in both the 1989 and 1993 Teenage Attitude and Practice Surveys. These adolescents (aged 15 to 22 years old in 1993) were identified as non-smokers (never smoked) and experimental smokers (had smoked or tried a cigarette but had not smoked 100 cigarettes in their life time and had not smoked in the past 30 days) in the baseline 1989 survey. The information obtained from these surveys included measures of smoking behavior and a series of factors related to smoking models in the respondents' social environments. Specifically, these questions asked respondents if their father smoked, mother smoked, older brother smoked, and older sister smoked. They were also asked "of their four best male friends, how many smoked," and "of their four best female friends, how many smoked." In addition, the respondents were asked if their steady boy/girl friend smoked. Odds ratios were used to measure the associations between adolescent smoking progress and smoking behaviors of parents, siblings, and best friends.

> ***Any smoking by an adolescent, including experimental smoking, dramatically increases the risk of that adolescent becoming a regular adult smoker.***

Results

Smoking Progress for Non-smokers. Of the 4,444 non-smokers in 1989, 28.2% became experimental smokers, and 10.9% became regular smokers during a 3-year span. (Regular smokers were defined as those adolescents who were currently smoking, had smoked in the past 30 days, and had smoked at least 100 cigarettes in their lifetimes.) Adolescents whose best friends smoked were more likely to initiate smoking than those adolescents whose best friends were non-smokers. However, if adolescents not only had best friends who were smokers, but also had parents or siblings who smoked, they were much more likely to become regular smokers.

Smoking Progress for Experimental Smokers. Of the 2,075 experimental smokers in 1989, 29.6% became regular smokers during a 3-year span. Male adolescents who had best friends who smoked were significantly at-risk for moving from experimental smoking to regular smoking. None of the family smoking and sibling smoking variables were significantly related to this smoking progress.

For female adolescents, three social factors were significantly associated with the transition from experimental smoker to regular smoker. Having a father who smoked, having best friends who smoked and having had a steady boyfriend who smoked were all significant factors in placing the female adolescent at risk for moving from experimental smoking to regular smoking. No sibling or mother variables were significantly related to smoking progress.

Discussion

Of all the findings, the social factor which consistently predicted adolescent smoking progress seemed to be the smoking status of best friends. This finding confirmed previous literature which indicated that peer smoking behavior was the most important factor influencing transition to experimental or to regular smoking. Regarding the mechanism of peer influence, some have suggested that peer influence is largely the result of social selection as adolescent smokers seek out friends who are smokers. Consequently, peer models cannot be regarded as a sole causal factor for adolescent smoking initiation and movement towards advanced stages of smoking acquisition. Social selection as a mechanism of the peer influence has been supported by other researchers.

Overall, the strength of the prediction of adolescent smoking progress using social variables was not strong. These findings appeared to be congruent with previous researchers who found that the ability of an adolescent's social psychological factors, which included social factors, to predict long-term young-adult smoking was weak. Perhaps the most surprising finding of this study was that parental smoking had little effect on adolescent smoking progress. This finding was neither supportive of the social influence model, nor of the current literature. A number of studies have found a significant relationship between the smoking behavior of parents and their children. According to the social influence model, directly experiencing a behavior and its associated rewards and punishment influence beliefs about the consequences of the behavior and helps to formulate evaluative definitions of a behavior. Parents may influence their adolescent children's smoking by providing evaluative definitions of smoking and by influencing the adolescents' expected consequences of smoking. Therefore, some researchers believe that parental smoking behavior should receive more emphasis in smoking prevention program for adolescents. Our findings, however, did not lend support to these beliefs. Though no clear explanations could be provided regarding these different results, a few speculations may be made. Most previous research in adolescent smoking were cross-sectional designs in which smoking progress could not be determined. Also, cross-sectional studies usually do not provide information on whether parents became smokers before or after their children started to smoke. Consequently, the influence of parents' smoking on their children's smoking behavior cannot be predicted. Perhaps a detailed history of parental smoking as well as their children's smoking behavior, would be most useful in delineating the true influence of parent smoking on their children as suggested by researchers. Unfortunately, to our knowledge, no study has attempted this line of research. ◆

The social factor which consistently predicted adolescent smoking progress seemed to be the smoking status of best friends.

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RESOURCES

American Lung Association
www.lungUSA.org • (212) 315-8700
The American Lung Association (ALA) has a special section on teens and smoking which includes statistics, fact sheets, advertising and information on a teen tobacco cessation program designed and evaluated by the ALA and West Virginia University.

CDC's Tobacco Information and Prevention Sources
www.cdc.gov/tobacco/tobacco.htm
Designed by the Office on Smoking and Health, this site contains an extensive library of research, data, and reports grouped by topic, a number of resources for smoking cessation assistance, and a number of educational materials for use by employers, health care professionals, parents, educators, and youth.

Department of Adolescent and School Health
www.cdc.gov/nccdphp/dash
This site deals with a number of topics, not just teen tobacco use. However, under the "Programs That Work" link are two tobacco use prevention programs, Project Toward No Tobacco Use (Project TNT) and Life Skills Training. Information about the curriculum and references to several evaluations are provided. Under "School Health Program Guidelines" are a number of resources, including actions that teachers, school administrators and board members can take to help young people avoid using tobacco products.

Spit (Smokeless) Tobacco Use by High School Baseball Athletes in Urban and Rural Areas of California

By Margaret M. Walsh, Ed.D., James Ellison, D.D.S., M.P.H., Joan F. Hilton, Sc.D., M.P.H., Margaret Chesney, Ph.D., and Virginia L. Ernster, Ph.D.

The negative health effects associated with spit tobacco use include oral cancer, cardiovascular disease, periodontal disease, and nicotine addiction among others. In addition, spit tobacco use has been shown to produce similar levels of nicotine in the body as does cigarette smoking.

Athletes, particularly baseball players, are known to be heavy users of spit tobacco. Studies have found use rates of 34% and 39% among professional baseball players and 57% among National Collegiate Athletic Association baseball players. Although national data for high school males show that 12% use spit tobacco products regularly, and studies have documented that young males frequently use spit tobacco when playing or watching a sport, no data focusing specifically on spit tobacco use by high school baseball athletes have been reported to date. As a result, we conducted a cross sectional study to describe the prevalence, patterns, and correlates of spit tobacco use in a sample of high school baseball athletes in California, to inform the need for interventions targeting this population.

Methods

High schools included in our study were selected randomly from a list of all public high schools with baseball teams. In all, 106 high schools were contacted: 7 refused to participate, 43 failed to respond to phone messages, and 17 were ineligible because they had discontinued their baseball programs. Fifteen of the 39 high schools enrolled in the study were located in rural areas, representing 7% of rural high schools in California with baseball teams. (A high school was considered rural if it was located in a town with a population of less than 50,000 residents and in a county with a population density of less than 1,000 persons per square mile.) Twenty-four of the high schools were in urban areas representing 4% of urban California high schools with baseball teams.

At the study schools we recruited 1,226 baseball athletes, 485 at 15 rural high schools and 741 at 24 urban high schools, to participate in the study. Most participants were white (64%), but a smaller proportion of the urban sample was white (58%) than of the rural sample (73%). The mean age of initiation of spit tobacco use was 14.0 years.

Results/Discussion

Prevalence

Of the 1,226 players in our study, 54% reported they had never used spit tobacco, 21% reported they had tried it, 10% reported former regular use, and 15% reported current regular use. We found that prevalence of current spit tobacco use among high school baseball players in California was 15% overall, 19% in rural areas, and 12% in urban areas. Our findings for high school baseball athletes are much higher than the 2% reported in 1996 for teenage males in California who ever used spit tobacco, and reflect the association of spit tobacco use with baseball.

Overall, Whites (17%) and Native Americans (18%) were more likely to report spit tobacco use than were Asians (10%) and Hispanics (11%); African Americans had the lowest prevalence rate (5%). Although prevalence of current spit tobacco use was much higher among white than among non-white groups as a whole (17% v. 11%), use of spit tobacco by non-whites in rural areas was much greater than that of non-whites in urban areas (22% v. 6%). Spit tobacco use among white athletes did not differ by rural/urban location. Tobacco control programs targeting baseball athletes in rural areas should make use of non-white as well as white positive role models/spokespersons.

> ***Use of spit tobacco by non-whites in rural areas was much greater than that of non-whites in urban areas.***

Addiction

Table 1 shows the reasons users gave for using spit tobacco. These data indicate that reasons connected to nicotine addiction were consistently rated as important by spit tobacco users. The two reasons considered important by 66% of spit tobacco users were "a strong craving for it" and "because it was satisfying and they had not found a good substitute." This emphasizes the need for interventions to interrupt the addiction process. In addition, 37% of these young spit-tobacco-using

TABLE 1

Reasons for Use Identified as "Important" by Spit Tobacco* Users (n-131)

	%
It is satisfying and I have not found a good substitute	66
I have a strong craving for it	66
It helps me with boredom	64
My friends use it	64
I do it without thinking too much about it	64
Baseball season started again	55
I don't think it's as bad for my health as others may think	52
It helps me handle stress at school	34
I don't like withdrawal symptoms	30
I feel pressure to use from friends at school	23
It helps me handle problems in personal life	21
It helps me keep my weight down	21

**Spit tobacco use more than once a month.*

baseball athletes used snuff exclusively, and 46% used both snuff and chewing tobacco (see Table 2). We found a trend based on addiction-related variables indicating that athletes who used both snuff and chew tended to be more addicted to nicotine than those who used only snuff, who in turn tended to be more addicted than those who used only chewing tobacco. Although these findings should be interpreted with caution because of the small number of exclusive chewing tobacco users in our sample, it does appear that snuff users and combined product users are more physically dependent on nicotine and consequently may find it more difficult to quit the habit than chewing tobacco users.

TABLE 2

Definitions of Snuff and Chewing Tobacco

There are two major types of spit tobacco used in the United States: snuff and chewing tobacco.

Snuff is a finely ground or shredded tobacco commonly sold in a small, round tin can. Users put a "dip" (pinch) of snuff between the lower lip or cheek and gum, where it stays in place until removed. In addition to being packaged loosely, moist snuff is available in small sachets similar to tea bags.

Chewing Tobacco is more coarsely cut than is snuff and is packaged in loose or plug form, most commonly in pouches. Users put a "chew" or "wad" of tobacco in the cheek pouch and chew on it until it is removed.

There are chemical and physical properties that account for the difference in addiction potential between chewing tobacco and most forms of moist snuff. Nicotine addiction is a function of not just the quantity of nicotine extracted from the product, but also of the rate of delivery. In our study, 50% of current snuff users named Copenhagen or Kodiak as their usual brand. These high pH brands have higher concentrations of bioavailable nicotine and are associated with more rapid absorption of nicotine across oral mucosa. Therefore, they have a higher addiction potential than chewing tobacco which tends to be absorbed more slowly.

That use of snuff was much more common in this group than use of chewing tobacco is of concern because the strongest data associating the use of spit tobacco with oral lesions, gingival recession, and oral cancer were obtained in snuff users.

Knowledge

A significant number of spit tobacco users in this study did not know that nicotine was addicting (11%), erroneously believed that spit tobacco use improved athletic performance (13%), and perceived little personal risk of adverse health effects associated with their use of spit tobacco (see Table 3). Compared with players who knew the correct answers, the odds of using spit tobacco was higher among players who thought spit tobacco use improved athletic performance, and that nicotine was not addicting. Intervention programs are needed to correct these misconceptions.

Other Drug Use

Current spit tobacco use was higher among current and former cigarette smokers than among those who never smoked (Table 4). Spit tobacco use was also strongly associated with use of alcohol; players who drank alcohol were 9 times more likely to use spit tobacco than non-drinkers (those who had had fewer than 10 drinks in the past year). This finding is a cause for concern because spit tobacco and alcohol and/or cigarette use may have a synergistic effect on the development of oral cancer. In addition, it suggests an addictive pattern of behavior and the need to integrate intervention programs for these substances.

Social Influences

In California, all schools are required to have a tobacco-free policy. The rate of spit tobacco use by baseball athletes may reflect a lack of support from the coaches, through either negative role modeling or reticence to enforce the ban. The odds of spit tobacco use for players who perceived that their high school baseball coach used spit tobacco were 3 times higher than for players who perceived that their coach did not use spit tobacco (Table 4). This suggests the need to provide effective inservice programs for baseball coaches to gain their support for policy level interventions targeting athletes, to promote positive role modeling, and to offer spit tobacco use cessation assistance. Research is needed to examine the effect of such staff development programs.

> ***Nicotine addiction is a function of not just the quantity of nicotine extracted from the product, but also of the rate of delivery.***

TABLE 3

Prevalence of Spit Tobacco Use*
by Perceptions of Risk and Knowledge

	n (%)	Prevalence of Spit Tobacco Use (%)	Odds Ratio
PERCEPTION OF RISK			
It would give me a sore mouth or throat			
Slightly/very unlikely	328 (27)	30	4.2
Slightly/very likely	883 (73)	9	1.0
It would give me mouth cancer			
Slightly/very unlikely	146 (12)	34	3.6
Slightly/very likely	1067 (88)	12	1.0
It would give me gum disease			
Slightly/very unlikely	136 (11)	32	3.3
Slightly/very likely	1078 (89)	13	1.0
I would need surgery for oral cancer			
Slightly/very unlikely	448 (37)	19	1.6
Slightly/very likely	763 (63)	13	1.0
I would become addicted to spit tobacco			
Slightly/very unlikely	285 (23)	19	1.4
Slightly/very likely	927 (77)	14	1.0
KNOWLEDGE			
Using spit tobacco improves athletic performance			
True and don't know (incorrect)	160 (13)	24	2.0
False (correct)	1063 (87)	14	1.0
Nicotine is addicting			
False and don't know (incorrect)	131 (11)	21	1.6
True (correct)	1092 (89)	14	1.0

**Spit tobacco use more than once a month.*

Also consistent with the findings of others, we found peer influence, especially that of the best friend, to have the strongest association with spit tobacco use. Athletes in this study were 22 times more likely to use spit tobacco if their best friend used it. In addition, spit tobacco users were also more likely to perceive that they would be liked if they used spit tobacco and in general found it hard to say no in the face of social pressure to use (Table 5). Moreover, athletes who saw spit tobacco use as a social norm among their peers were more likely to be current users themselves. Twenty percent of spit tobacco using athletes in this study perceived that spit tobacco was more commonly used by teammates and other same-age baseball players than it actually is. Intervention programs targeting high school baseball athletes should highlight the fact that most do not use spit tobacco and should address conditions in the social environment that make them vulnerable to initiating spit tobacco use.

Athletes who found it hard to say no when offered spit tobacco were much more likely to use spit tobacco than athletes who did not find it hard to say no. Training in refusal skills may be an important part of spit tobacco prevention programs.

Changing the social norms that sanction and support spit tobacco use in the culture of baseball is essential. Use of peer leaders to endorse behavioral innovation in order to alter social norms have been used effectively in other research. In addition, enlisting the support of well-known non-using professional players, as suggested by Gottlieb and colleagues, or of college athletes who have struggled either with quitting use of spit tobacco or with the temptation to begin using spit tobacco, might influence social norms to support non-use. Such presentations would reinforce player decisions not to use and provide external cues to motivate current users to stop. Programs targeting spit tobacco use among professional baseball athletes are also extremely important because high-profile baseball athletes are potent role models for youth.

The big challenge, however, is to discover effective strategies to convince this adolescent population of their personal vulnerability to health risks associated with spit tobacco use and at the same time to override what they see as the positive aspects, including the approval of their male peers. Such a program might include documentation of the cynical exploitation of their age group by the tobacco companies. Enlisting dental professionals to point out tobacco related lesions in the players' mouths or in intraoral photographs of other athletes and to offer cessation advice might also be effective.

> ***Our findings indicate that considerable experimentation with spit tobacco products occurs among high school baseball athletes in California.***

It is important that those spit tobacco users who indicate they want to quit are provided with knowledge and skills needed to get ready to quit, to cope with cravings and triggers for use, and to reduce nicotine withdrawal symptoms if necessary.

TABLE 4

Prevalence of Current Spit Tobacco Use* by Other Substance Use and Significant Others' Use

	n (%)	Prevalence of Spit Tobacco Use (%)	Odds Ratio
SUBSTANCE USE			
Alcohol User			
Current use†	547	29	9.6
No current use	678	4	1.0
Smoking History			
Current smoker‡	46	41	5.3
Former smoker	122	33	3.7
Never smoked	1056	12	1.0
ATHLETE'S PERCEPTION			
Coach Uses Spit Tobacco			
Yes	517	22	3.1
No	403	11	1.4
Unknown	304	8	1.0
Best Friend Uses Spit Tobacco			
Regular	109	55	22.1
Occasional	214	36	9.9
Non-user	894	5	1.0

**Spit tobacco use more than once a month.*

† ≥10 drinks consumed in the past 12 months.

‡ Daily use of at least one cigarette.

TABLE 5

Prevalence of Current Spit Tobacco Use* by Social Influence Items

	n (%)	Prevalence of Spit Tobacco Use (%)	Odds Ratio
How many athletes on your team use spit tobacco?			
At least half	248 (20)	33	4.3
Less than half	972 (80)	10	1.0
In general, how many baseball athletes your age use spit tobacco?			
At least half	382 (31)	29	4.4
Less than half	836 (69)	9	1.0
Do you think people would like you if you used spit tobacco?			
Yes	758 (63)	19	2.7
No	175 (15)	8	1.0
Not sure	277 (22)	8	1.0
When people try to get you to use spit tobacco, is it hard to say no?			
Yes	52 (4)	46	36.0
Sometimes	137 (11)	39	27.3
No	809 (67)	12	5.5
No one ever tried	215 (18)	3	1.0

** Spit tobacco use more than once a month.*

In summary, our findings indicate that considerable experimentation with spit tobacco products occurs among high school baseball athletes in California, and many are using spit tobacco regularly. Spit tobacco interventions targeting this population represent an important opportunity to stop the transition from experimental spit tobacco use to tobacco dependence, especially in rural areas.

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UPCOMING TOPICS

Homeless Youth

Homeless youth lead unstable and hazardous lives and are at high-risk for health problems. The U.S. Department of Education estimates that 23% of homeless children and youth are not attending school. The September 2001 issue of *The Prevention Researcher* will focus on the special needs of homeless youth.

Adolescent Depression

Prevalence rates for adolescent depression varies by research study and the age of the youth, but is estimated to be around 5%. Additionally, many youth suffer from significant impairment but don't meet the criteria for Major Depression. The November 2001 issue of *The Prevention Researcher* will focus on adolescent depression.

Other future topics include Mentoring and Involving Parents. Additionally, our December 2001 Resource Issue will include an exclusive interview with Dr. Andrew Weil on holistic prevention and at-risk youth.

Competence Skills Help Deter Smoking Among Inner-City Adolescents

By Jennifer A. Epstein, Ph.D., Kenneth W. Griffin, Ph.D., M.P.H., and Gilbert J. Botvin, Ph.D.

Each day in the United States more than 6,000 adolescents try their first cigarette and nearly 1-in-5 eighth graders have smoked in the past month. Smoking at such young ages increases the likelihood of nicotine addiction. Theoretical formulations about adolescent smoking behavior posit that intrapersonal characteristics related to general competence, such as decision making and personal efficacy, have a central role in determining vulnerability to smoking. Even though adolescents recognized the harm of smoking, they greatly overestimated its prevalence among peers and adults, negating the notion that smoking initiation is an informed decision. High personal efficacy should help adolescents combat peer pressure to smoke and exert control over their own behavior. Some studies have detected a direct relationship between smoking and poor decision-making skills or low efficacy, but others conducted with predominantly ethnic minority inner-city adolescents have not. Even if decision making and personal efficacy are not directly associated with smoking, these general competence factors may be a foundation for factors with a closer relationship to smoking.

An example of a critical competence skill that is more closely related to smoking is the ability to refuse assertively. Reviews indicate that the smoking behavior of family members and particularly friends greatly influences adolescents to smoke. The role of the smoking status of family members and friends in adolescent smoking has also been demonstrated in Hispanic and African American inner-city youth. If adolescents had the ability to resist specific social pressures to smoke from family, friends, and the media, then they would be less likely to smoke. In fact, refusal assertiveness has been negatively linked to cigarette smoking among African American inner-city youth.

Refusal skills training teaches adolescents how to recognize, handle, or avoid situations in which they have a high likelihood of experiencing peer pressure to smoke. Evaluations of this approach verify its effectiveness. But another approach to smoking prevention focusing on competence enhancement incorporates refusal skills training within the context of a broader, more comprehensive training which teaches general personal and social skills. Unlike refusal skills training, this more generic skills approach posits that it is necessary to provide adolescents with a wide range of life skills in order to reduce potential motivations to smoke and to decrease vulnerability to social pressures to smoke. Teaching adolescents decision-making and other life skills is intended to increase personal efficacy.

Evaluations of competence enhancement prevention shows its effectiveness with predominantly white populations and with predominantly minority inner-city populations. Even though these comprehensive skills programs proved effective in reducing adolescent smoking, additional research is needed to determine whether general competence is truly a necessary foundation for refusal assertiveness which then serves to decrease smoking.

Since approaches that teach only refusal skills have proven effective, some might argue there is no need to increase the length, breadth, and training requirements necessitated by the competence enhancement approaches. Because of the role of program delivery and other factors that can decrease the effectiveness of a prevention intervention, long-term group or individual studies investigating the causes of smoking can be particularly helpful in developing models to test these ideas.

One way to test the role of decision making and personal efficacy in adolescent smoking is to examine their indirect effect on smoking through refusal assertiveness. Adolescents who have not mastered decision making skills may select a quick solution (for example, do what my friends do—smoke) rather than working out all the possible consequences and seeing the conflict with their own personal values or beliefs. As a result, refusal skills may be insufficient preparation for combating social pressures to smoke. Similarly, if adolescents do not feel capable of performing behaviors because of low personal efficacy, then they may not attempt to use the refusal skills they have learned.

The purpose of this study was to test the principles underlying the competence enhancement approach to smoking prevention with inner city, minority adolescents. To date, it has only been theoretically stated that general competence will enhance refusal assertiveness. This study investigates whether greater levels of general competence (decision-making skills and personal efficacy) are linked to subsequent refusal assertiveness and whether this greater refusal assertiveness is associated with less smoking. Such a model would provide support for teaching general competence skills along with refusal skills within the context of a smoking prevention program.

Method

A total of 22 middle and junior high schools in New York City with 25% or more Hispanic students participated in this study. Middle schools included grades 6 to 8 and junior high schools covered grades 7 to 9. The majority of the 22 schools served youth from families with average incomes at or below 150% of the federal poverty level. All sixth and seventh graders in English speaking, mainstream classes were eligible to participate by completing the study questionnaires. Of these, more than 90% of the students completed the initial baseline survey. Students also completed surveys at 1-year and 2-year follow-ups.

At baseline, 2,400 students completed questionnaires. The retention rates over the course of the study (81% at 1-year and 63% at 2-year follow-ups) compare favorably with retention rates for similar school-based studies, considering the recognized difficulty of conducting longitudinal research with inner city minority youth owing to high rates of mobility and absenteeism. The panel sample across the three time points (baseline, 1-year, 2-year) consisted of 1,459 students. The mean age at baseline for the panel sample was 12.4 and the sample was 46% boys. In terms of ethnicity, this sample was 54% Hispanic, 20% African American, 7% Asian, 16% White, and 3% other.

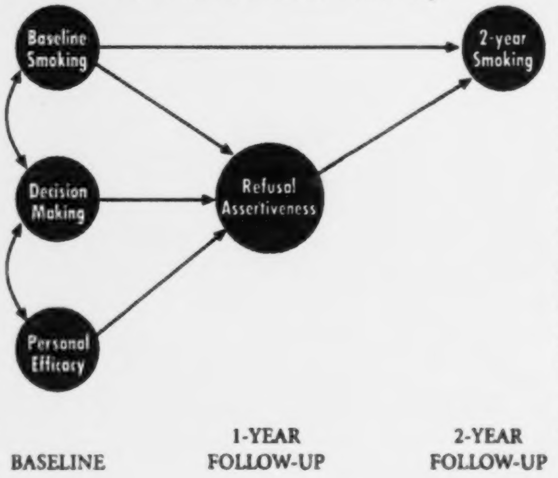
Participating students completed questionnaires that measured self-reported smoking behavior and psychological factors hypothesized to be related to smoking. Students completed these surveys during a regular 40-minute class period. Carbon monoxide breath samples were collected before students completed the questionnaire, this technique has been found to enhance the veracity of self-reported smoking data.

Results

As expected, analysis of smoking prevalence rates indicated that smoking levels increased substantially from baseline (sixth and seventh graders) to the 2-year follow-up (eighth and ninth graders). At baseline, 15.4% of participants reported that they had ever smoked, 10.6% smoked in the past year, 3.3% smoked in past month, and 1.4% smoked in the past week. At follow-up, 30.4% of eighth and ninth graders reported that they had ever smoked, 22.0% reported smoking in the past year, 10.6% reported smoking in the past month, and 5.0% reported smoking in the past week.

Factor analysis and structural equations modeling were both performed on the data. Several of the components from the factor analysis model were significantly intercorrelated. The strongest relationships were between refusal assertiveness and 2-year smoking, while baseline and 2-year smoking were highly correlated as expected. Furthermore, decision making and personal efficacy were moderately associated. Structural equations modeling found that each of the three baseline factors (baseline smoking, decision making, and personal efficacy) directly predicted refusal assertiveness. Decision making and personal efficacy predicted higher refusal assertiveness, while baseline smoking predicted lower refusal assertiveness. Additionally, refusal assertiveness predicted less 2-year smoking.

Factors Which Significantly Predicted Refusal Assertiveness and 2-Year Smoking



Discussion

This study was designed to increase our understanding of the causes of cigarette smoking among inner-city youth and provide additional information to guide efforts to refine prevention approaches. These findings highlight the importance of both generic and smoking-specific etiologic factors and suggest that smoking prevention programs should include components to enhance broader competence in addition to providing training in refusal skills. This is because youth with better personal efficacy and decision making skills are better able to implement smoking refusal strategies, which in turn reduce smoking behavior. This is an important finding because research that only examined direct effects of sound decision-making and high personal efficacy as deterrents to adolescent smoking have been mixed with some showing a relationship and others showing no relationship. Yet in the current tested model, general competence, as represented by decision making and personal efficacy, served as a critical foundation for refusal skills. Although refusal skills training requires a briefer investment of time, this study implies that the additional time and effort to teach general competence skills in addition to refusal skills may be very worthwhile.

According to these findings, adolescents whose decision-making skills were deficient were less likely to use refusal skills and more likely to succumb to pro-smoking social influences. These adolescents might not have been able to weigh adequately the consequences of peer pressure to smoke or compromise by being assertive about not smoking without offending their friends. For example, they may have decided to just smoke one cigarette to fit in with their friends without evaluating the long-term consequences (for example, their friends will expect them to smoke again next time). Such faulty decision making meant less frequent use of refusal skills and a greater tendency to smoke. In contrast, adolescents with adequate decision making skills may have been more likely able to weigh the consequences of succumbing to peer pressure and realize they could most appropriately respond by utilizing assertive refusal skills. Thinking through the consequences and making use of other sound decision-making practices would facilitate frequent use of refusal skills, decreasing subsequent smoking. In terms of personal efficacy, adolescents who believed in their own ability to perform behaviors appeared to be more prepared to engage in refusal skills that minimized later smoking. Knowledge of refusal skills coupled with the belief in being able to actually use these skills seemed to be a fundamental combination in diminishing subsequent smoking.

Several limitations of the current study should be noted. Since only a limited number of variables were included, the tested model is not the only possible good fitting model of smoking behavior among inner-city minority adolescents. Even so, it is consistent with prior prevention research conducted with inner-city minority adolescents. Because adolescents participating in this study were students, these results cannot be generalized to nonstudent populations. Yet, the middle school period has low dropout rates and absentees were pursued on two return data collections, lessening the detrimental impact relative to conducting such a study in high school and without pursuit of absentees. As the study was only conducted with inner-city students, it is possible that different results might be obtained with suburban or rural populations. Finally, the loss of high-end smokers from the panel sample may have attenuated the estimation of variable relationships and may mean the findings cannot be generalized to adolescents who are heavier smokers.

Although smoking prevention programs that focused on refusal skills training have proven effective, this prevention approach can be further improved through the addition of other personal and social skills training. Specifically, inclusion of broader competence skills to enhance personal efficacy and teach decision-making and problem-solving skills appears warranted by these findings. The current study showed the importance of more general competence factors in enhancing refusal assertiveness and deterring adolescent smoking. Consequently, the tested model provided support for the competence enhancement approach to smoking prevention over the refusal skills training only approach.

Refusal training approaches teach adolescents information, norms, and refusal skills with a problem specific focus. But this type of approach assumes that adolescents are naturally motivated to resist pro-smoking influences. In contrast, the competence enhancement approach to smoking prevention recognizes that training in a broader array of personal and social skills helps reduce the motivation to smoke and does not make the assumption that adolescents want to avoid social influences to smoke. Competence enhancement approaches include both aspects of a refusal skills program (that is, training in handling social influences to smoke) and a more comprehensive personal and social skills training program (setting and achieving goals, decision making and problem solving, coping strategies for stress and anxiety, communicating effectively, developing friendships, and general assertiveness). Learning this comprehensive array of skills is designed to boost personal efficacy. Moreover, these skills can be applied more generally to a variety of challenges that adolescents face including, but not limited to, smoking. The link between each general competence measure with refusal assertiveness in the present study suggests that decision making and personal efficacy motivated the use of refusal skills.

Youth with better personal efficacy and decision making skills are better able to implement smoking refusal strategies.

Reviews of the smoking prevention literature indicate that the competence enhancement approaches have proven long-term effectiveness, as well as short-term effectiveness, and generalizability to ethnic minority groups. For example, a competence enhancement program delivered during junior high school reduced pack-a-day smoking at the end of high school by 25% compared to a control group according to a large, long-term study. This body of research combined with the current study provides empirical support for a smoking prevention approach that can be implemented in a school setting and has a dual emphasis on resistance skills training and more general personal and social skills training. Moreover, the results of the current study underscore the utility of such an approach for inner city, minority adolescents. Future research is needed to determine the effectiveness of this prevention approach with other populations, as well as to determine the relative importance of the various personal and social skills taught in this type of prevention approach.

Jennifer A. Epstein, Ph.D. and Kenneth W. Griffin, Ph.D., M.P.H. are Assistant Professors in the Department of Public Health at Cornell University Medical College. Gilbert J. Botvin, Ph.D. is a Professor and Director of the Institute for Prevention Research at Cornell University Medical College.

This article is condensed from J.A. Epstein, K.W. Griffin, and G.J. Botvin (2000). Competence skills help deter smoking among inner city adolescents. *Tobacco Control*, 9, 33-39. It appears here with permission from the publisher.

For a similar study concerning alcohol use please see: J.A. Epstein, K.W. Griffin and G.J. Botvin (2000). Role of general and specific competence skills in protecting inner-city youth from alcohol use. *Journal of Studies on Alcohol*, 61, 379-386.

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Evaluation of School-Based Adolescent Tobacco Cessation Programs

By Debbie Coleman-Wallace, Dr.PH, Jerry W. Lee, Ph.D., Susanne Montgomery, Ph.D., Glen Blix, Dr.PH, and Dongqing Terry Wang, M.S.P.H.

Tobacco use constitutes the most preventable cause of morbidity and mortality in the United States, accounting for more deaths than alcohol, car accidents, heroin, cocaine, crack, homicide, firearms, and AIDS combined. Much of the damage due to smoking, however, can be reversed within one year of quitting. Over the past decade smoking declined among the adult population, but not among adolescents. Despite numerous smoking prevention programs, roughly 9 of 10 adult smokers started smoking during adolescence.

National surveys reveal that most adolescent smokers made one or more unsuccessful attempts to quit smoking. Adolescents also tend to overestimate the success of their peers at quitting. According to the 1989 Teenage Attitudes and Practices Survey only about 1.5% of teens who ever smoked were successful at smoking cessation. Therefore, adolescents want to quit, but they lack the ability or the resources necessary to quit smoking.

The literature contains information about adult smoking cessation programs but lacks information about adolescent smoking cessation programs, because few adolescent programs exist, and of these, few have been evaluated or published. Prevention programs in schools concentrate on primary prevention. Adolescents often experiment with smoking or smokeless (chew/dip) tobacco products. This experimentation often results in the experimenters becoming addicted. These addicted adolescent tobacco users, in turn, increase the amount of peer pressure on their peers to use tobacco products, so the cycle continues unchecked because smoking cessation programs are not offered to adolescents who cannot quit on their own.

TABLE A

Stages of Change Model*

Behavioral changes occur in a cycle which can be divided into five stages.

Stage One – *Precontemplation*
An individual is not yet thinking about changing a behavior.

Stage Two – *Contemplation*
The individual starts to evaluate the pros and cons of the behavior.

Stage Three – *Preparation*
The individual makes the decision to change the behavior and develops a plan of action.

Stage Four – *Action*
The individual attempts the behavior change.

Stage Five – *Maintenance*
The individual tries to maintain the behavior change.

** From I.O. Prochaska and C. DiClemente (1983). Stages and processes of self-change in smoking: Toward an integrative model of change. Journal of Consulting and Clinical Psychology, Vol 5, pp. 390-395.*

Schools need effective smoking cessation programs. However, the Centers for Disease Control and Prevention (CDC) reports that evaluation of adolescent smoking cessation programs are typically anecdotal or descriptive. With lack of published literature concerning effective, developmentally appropriate programs for adolescent tobacco cessation, school administrators may be reluctant to commit time and limited resources to provide smoking cessation programs. This article addresses this need by conducting a quantitative and a qualitative evaluation of two adolescent programs.

The Program

The programs were implemented throughout the United States prior to formal evaluation which was conducted in six public high schools in Southern California. The programs were developed specifically for the adolescent population and address both smoking and smokeless tobacco use. The programs consisted of 8, one-hour sessions designed for small groups of 8 to 12 adolescents with an adult facilitator. The group provided social pressure or positive peer pressure to quit tobacco use. *The Tobacco Education Group* (TEG), is a general education program, which seeks to motivate tobacco users to have the desire to quit using tobacco. The TEG curriculum includes:

> ***National surveys reveal that most adolescent smokers made one or more unsuccessful attempts to quit smoking.***

- Personal reasons for smoking or chewing tobacco;
- Pressures to use tobacco;
- Demonstrations of short-term consequences of tobacco use; and
- Discussions of long-term consequences of tobacco use.

The Tobacco Awareness Program (TAP) is a tobacco cessation program. It was designed for adolescents who desire to quit using tobacco. The TAP curriculum includes:

- Short-term and long-term consequences of smoking;
- Triggers to tobacco use and coping strategies;
- Pitfalls to be expected during and after quitting;
- Use of culturally sensitive materials;
- Individual choice of methods to quit; and
- Weight management, which is of particular concern to adolescents.

Stages of Change Model

Together, TEG and TAP comprise a two-step approach to tobacco use cessation, based on Prochaska and DiClemente's stages of change model. According to this model, behavioral changes occur in a cycle which can be divided into five stages: *precontemplation, contemplation, preparation, action* and *maintenance* (See Table A). An individual may cycle through these stages several times before change is successful. This model has been extensively applied to smoking as well as other problem behaviors.

TEG and TAP were developed to address the needs of tobacco users at different stages of change. The premise is that a person not thinking about quitting tobacco use has a low readiness to change. Based on this premise, the program developer designed the intervention so that precontemplators and contemplators attend the TEG educational program to become motivated to quit using tobacco. Participants in the preparation, action, or maintenance stages of change should receive the TAP cessation program.

Methods

TEG and TAP were implemented in a Southern California high school district consisting of six regular high schools. Researchers collected data for two years, during the 1996 through 1998 school years. Programs operated district-wide with the approval of the school board and the parents and teachers association. This school district's policy required that all students have confidential access to the TAP cessation program without fear of reprimand from parents or guardians. This approach encouraged students to volunteer for the TAP cessation program.

As an alternative to suspension, administrators assigned students caught using tobacco in violation of the tobacco-free policy to the TEG education program. A few students who expressed a strong desire to quit tobacco use were assigned to the TAP cessation program. Since the programs were conducted in groups, group pressure played a role in the success of the programs. Therefore, it is likely that participants caught using tobacco, who were at the precontemplation stage yet incorrectly placed in the TAP cessation program, would be counter-productive to participants trying to quit. It should, however, be noted that this bias is most likely to result in no change among participants.

Recruiting adolescent tobacco users to attend the programs was challenging, but even more difficult was recruiting the control group which did not receive any programs. To recruit a control group, monetary incentives of $3 for each survey completed were given to all treatment and control participants. As a result, 22 controls completed pre-test and post-test surveys. The control group had considerably more missing data compared to the intervention groups.

Participants and controls were given the same self-administered pre-test and post-test surveys. This study was a separately funded, external evaluation, so no changes were made to the existing program designs.

The qualitative study revealed that facilitators felt students were doing them a favor in serving as controls, so facilitators chose to not scrutinize their surveys. Consequently, given the control group's disproportionately smaller sample size and missing data, much of the data analysis could not be completed for the control group. Therefore, most of the data analysis reported involved comparing the two intervention groups, TEG vs. TAP. However, TEG participants may provide a better comparison group for TAP since TEG participants received a basic educational program, while the control group received no program. Students generally self-selected to the interventions based on the stages of change. Students who wanted help to quit volunteered for the TAP cessation program, while students caught using tobacco in violation of school policy were assigned to the TEG educational program. Facilitators conducted the TEG educational program during lunch time as punishment for using tobacco in violation of the tobacco-free school policy. On the other hand, students wanting to quit tobacco use attended the TAP cessation program during a regular class period. The control group comprised adolescent smokers who did not attend either program.

Results

A total of 201 participants attended the TEG educational program in lieu of suspension. Of the 128 TAP participants, 101 volunteered for the TAP cessation program, and 27 were caught using tobacco and assigned by administrators to TAP instead of TEG. Participants' average age was 15.5 years, with 12 years reported as the average age of smoking initiation. Baseline smoking did not differ among TEG and TAP program participants, and the control group. At baseline, these adolescents smoked an average of one-half pack to one pack of cigarettes daily.

> ***The literature shows that quitting smoking involves a process that may take several attempts to achieve.***

Participants reported no differences in the level of addiction to smoking. Other characteristics including the perception that most adolescents use tobacco and that adolescents are easily addicted to tobacco revealed no significant differences between TEG and TAP participants and controls. At baseline, all participants and controls equally feared getting cancer from tobacco use and equally regarded tobacco use as a problem. These results suggest that neither knowledge nor fear are adequate motivations for adolescents to want to quit tobacco use, and both are independent of whether or not adolescents were caught using tobacco at school.

A significant difference occurred in the gender make-up of TEG versus TAP. Only 29% of TEG participants were female. Since all participants in the TEG educational program were caught smoking in violation of school policy, the resulting gender composition of TEG participants reveals some significant differences. Results indicate that males (67.7%) were caught smoking more often than females in this school district. Yet, results show that more females (55.5%) attended the TAP voluntary cessation program, even after adjusting for the number of participants who were mandatory TAP participants.

Program Outcomes

Participants in both TEG and TAP significantly reduced the amount of cigarettes used daily, while controls did not decrease smoking over the same time period. This difference in smoking between treatment and control groups at the end of the program was significant. Of TAP cessation program participants who reported smoking at baseline, 15% reported having quit tobacco use at the end of the program. The mandatory TAP participants (who attended TAP because they were caught smoking) had a quit rate of 9%, a significantly lower quit rate than volunteer participants (16% quit rate). TEG participants reported a 12% quit rate. Note that the quit rates reported here are based on all participants. Therefore, those who missed the post-test

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were treated as non-quitters. The qualitative study revealed that facilitators did not understand that students who missed the post-test, including students who graduated early, would adversely affect the program evaluation.

The TEG education program did not significantly decrease precontemplation among participants, while TAP participants significantly decreased in precontemplation. Neither TEG nor TAP significantly increased contemplation among participants. Unlike participants in the TEG program, TAP participants increased in action. Both TEG and TAP participants increased maintenance.

Cigarette consumption decreased in both programs, but a greater change occurred among TAP cessation participants than among TEG education participants. Control participants did not significantly reduce the amount of cigarettes smoked during the same time period. Biochemical validation of the self-reported use suggests the programs were successful in reducing participants' tobacco use.

Both TEG and TAP participants showed no significant difference across gender for any of the stages of change variables. TEG participants also showed no significant differences between gender for each of the stages of change except for action. Females increased in action more than males in the TEG mandatory program but not in the TAP program.

Self-efficacy was predictive of end-of-program tobacco use for both TEG and TAP programs, after controlling for initial use. The amount of self-efficacy at the end of the program predicted more of the variance in tobacco use among TAP participants (33%) than TEG participants (22%). Self-efficacy, close friends, and family influence combined explained about half the variance in tobacco use for TAP participants while controlling for initial use. This regression model explained twice as much of the variance in tobacco use for TAP versus TEG participants. When initial self-efficacy was controlled for, in addition to controlling for initial use, 53% of the variance in tobacco use was explained by post-test self-efficacy, close friends, and family influence compared to 24% of the variance in tobacco use among TEG participants.

Conclusions

This study confirmed that the TEG tobacco education curriculum and the TAP cessation program were successful in reducing smoking among adolescents. The TAP program was more successful than the TEG program in moving participants along the stages of change toward tobacco abstinence. The literature shows that quitting smoking involves a process that may take several attempts to achieve. The stages of change model provides an alternative measure of success because it indicates the location of an individual along the continuum of the change process.

Another important measure of program success is self-efficacy. The TEG and TAP interventions appeared to increase adolescent self-efficacy to resist smoking as a result of attending either program. It also decreased cigarette use in both groups with a greater increase in the program aimed at cessation (TAP). When the authors controlled for baseline self-efficacy, post-test self-efficacy along with peer and family influence predicted twice as much of the variance of smoking outcome for the TAP program as it did for the TEG program.

> ***Research has shown that adolescents are unlikely to quit on their own, and the longer one uses tobacco the more difficult it is to quit.***

Research has shown that adolescents are unlikely to quit on their own, and the longer one uses tobacco the more difficult it is to quit. Therefore, effective adolescent tobacco cessation programs are needed, especially in schools as an alternative to discipline for violation of policy. More research should be conducted to improve access to and delivery of adolescent tobacco cessation programs that are developmentally appropriate. For example, recruiting precontemplators who use tobacco in violation of schools' tobacco-free policy should be geared toward increasing their readiness to change. Providing real solutions, not just punishment, for adolescents addicted to smoking should be an ethical imperative. ◆

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Homeless Youth in the United States

By *Jacqueline Smollar, Ph.D.*

Homeless youth in the United States are defined as individuals age twenty-one or younger who meet at least one of the following criteria:

- They have run away from their homes or from their alternative care placements and remained away for a long period of time with little or no connection with their families or caretakers.
- They have been pushed out of their homes or foster care placements, have been abandoned by their parents, or have left home for the streets with their parents' knowledge and consent.
- They have no stable place of residence; lack adult supervision, guidance, and care; and have little likelihood of reunification with parents.

The current number of homeless youth in the United States is not known and estimates are dated. In 1991 the National Network for Youth estimated the number of homeless youth ranged from 100,000 to 500,000. Although estimates of one to two million have appeared in the literature, these larger estimates include youth who run away from home and return fairly quickly, usually within a few days.

History of Homeless Youth

Homeless youth have been a part of U.S. society since its early history. During the settlement of the thirteen colonies and the ensuing westward expansion, many adolescents left home to seek adventure and economic opportunity. Homeless youth were also prevalent in the 1800s, but they were perceived as criminals constituting a significant social problem. In the early 1900s, many youth became homeless during the Great Depression. However, because large segments of the population were homeless during that era, the specific problem of youth homelessness was generally ignored.

In the 1960s, a new group of homeless youth, referred to as "runaways," began to be perceived as a significant social problem. Unlike earlier homeless youth, these adolescents left middle- and upper-class homes and forfeited the educational advantages and future professional prospects available to them as part of their families' socio-economic status. Congress enacted the Runaway Youth Act of 1974, which provided funds for establishing shelters to temporarily house the youth and reunite them with their parents. Shelter staff were required to inform parents or legal guardians of a youth's presence within forty-eight hours of arrival.

The Runaway Youth Act was revised in 1977 and renamed the Runaway and Homeless Youth Act. This revision was in response to reports from youth shelter personnel that they were seeing many youth who had not run away from home but had been pushed out of their homes, been abandoned by parents, or left home for life on the street with their parents' knowledge and consent. Although the 1977 act continued to stress family reunification, it acknowledged that both youth and their families needed extensive services for reunifications to be successfully accomplished.

> ***Many youth had not run away from home but had been pushed out of their homes, been abandoned by parents, or left home for life on the street with their parents' knowledge and consent.***

The number of teens seen by the shelter system who had not run away from home but had been pushed out, abandoned, or remained away with parental consent continued to increase during the 1980s. Shelter personnel reported that these youth exhibited multiple psychological and behavioral problems and came from families characterized by parental substance abuse, family violence, child maltreatment, long-term family conflict, and dysfunctional parents (many of whom had severe psychological and behavioral problems of their own).

In the 1990s, family dysfunction continued to be a primary cause of youth homelessness, although poverty once again emerged as a potential contributing factor. The 1990s also saw an increase in the numbers of youth who were homeless as a result of their families' homelessness.

Today's Homeless Youth

Accurate knowledge about homeless adolescents is limited by the fact that most studies focus on young people who are seen by the shelter system, which is only a small percentage of the total number of homeless youth. A report by the Office of the Inspector General estimated that only one in twelve homeless youth ever comes into contact with the shelter system. Despite the limitations, there is sufficient research to draw some general conclusions about the causes of youth homelessness, the characteristics of homeless youth, and the nature of life on the streets.

(Continued on Page 3)

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From the Editor's PC

Dear Colleague,

I welcome you to the September issue of *The Prevention Researcher.* This issue focuses on an important and often ignored segment of our population, homeless youth.

The issue begins with a look at homeless youth in the United States. Dr. Jacqueline Smollar of James Bell Associates looks at the prevalence and history of homeless youth, and discusses the impact homelessness has on adolescent development.

This article is followed with an examination of the educational needs of middle school homeless youth. Dr. Yvonne Vissing, author of *Out of Sight, Out of Mind: Homeless Children and Families in Small Town America,* discusses the educational issues surrounding homeless middle school youth and ways that schools can help them.

Jerry Fest, a long time advocate for street-dependent youth, discusses the street culture from a prevention prospective.

Melanie Wilson, M.S.W. and Alison Houghton, M.S.W. follow with a brief introduction into the McKinney Act's Education for Homeless Children and Youth Program.

Dr. Sara Jarvis, a private consultant; Dr. Elizabeth Lindsey from the University of North Carolina, Greensboro; and Dr. Nancy Williams from the University of Georgia, examine the roles of professionals in helping runaway and homeless youth.

And, finally, since homelessness is not only a big-city issue, Lisa Thrane and Kevin Yoder, both doctoral candidates at Iowa State University, examine the plight of rural homeless youth.

We would like to thank the New England Network for Child, Youth & Family Services for the case studies cited throughout this issue. We would also like to extend a special thank you to Diana Avery, M.S., Program Supervisor at Looking Glass Youth and Family Services' New Roads Program for homeless youth from 1994-2001 for doing a guest review.

Have a great autumn,

Steven Ungerleider, Ph.D.
Psychologist/Editor
The Prevention Researcher

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Recycled Paper

Homeless Youth in the United States *(Continued From Page 1)*

The primary cause of youth homelessness is family dysfunction, specifically parental neglect, physical or sexual abuse, family substance abuse, and family violence. Furthermore, these family problems have been found to be long-standing ones, rather than single episodes occurring shortly before youth leave home.

Homeless youth lead unstable and hazardous lives. They rarely reside in one location for long, and many have been found to live in four or more places over a six-month period. Homeless youth are at high risk for health problems, particularly hepatitis, respiratory problems (asthma and pneumonia), scabies, and trauma. They exhibit high levels of depression, suicidal tendencies, and suicide attempts, although one study reported that the incidence of suicide attempts was higher prior to leaving home than after leaving. Homeless youth also exhibit poor mental health, high use of alcohol and other drugs, and high risk factors for contracting HIV.

> **Accurate knowledge about homeless adolescents is limited by the fact that most studies focus on young people who are seen by the shelter system.**

Lesbian and gay homeless youth have been found to have a greater and more severe incidence of problems such as depression and suicide than other homeless youth. In one study of homeless street youth, 53% of lesbian and gay adolescents had attempted suicide, compared to 32% of a cohort that did not differentiate individuals by sexual orientation.

Although the developmental implications of youth homelessness in the United States have not been examined directly, the research on developmental processes during adolescence may be used to understand the consequences of youth homelessness. The results of this research and their implications for developmental outcomes among homeless youth may serve to guide future program, research, and policy initiatives directed toward this population.

Adolescent Development

Development is a process that occurs through reciprocal and dynamic interactions that take place between individuals and various aspects of their environment, with the person and the environment simultaneously influencing one another. Through examining the individual and environmental characteristics that foster positive development among adolescents, it is possible to draw inferences about the developmental prospects for homeless youth.

Four specific characteristics that foster positive developmental pathways from childhood to adulthood have been identified:

- A sense of industry and competency,
- A feeling of connectedness to others and to society,
- A sense of control over one's fate in life, and
- A stable sense of identity.

A Sense of Industry and Competency. Individuals who are confident in their own abilities develop a sense of industry and competency. Being involved in productive activities in school, at home, or in the community, and winning recognition for this productivity, nurtures this sense of industry and competency in children. This in turn fosters the development of a stable identity during adolescence and the perception of oneself as a potentially productive member of society.

CASE STUDY – NINA

Eighteen, pale, petite and dressed in black, Nina's ears, nose and fingers are studded with rings and her black hair is teased into a new-wave frizz. She is an alternative kid in a non-alternative town, and she knows how very different she is. A lesbian, she left for California when she was only 16. Though she was seeking greater acceptance, what she found was life on the streets. After a few months she hitched her way back to Maine. She found an apartment with a bunch of other kids, but recognizes now that none of them knew what they were doing. Life there was chaos. She worked nights, and often couldn't rouse herself in the morning to go to school. "I wanted to stay in school," she says now, looking back. I wanted to get my diploma, even go to college. But things change when life becomes more real. When you're living on your own, you work the third shift, you got to get up at six in the morning and walk to school? It's like, it's way too much of an inconvenience to worry about, so you end up not going." When she did go, she found that she was so far behind that she was chalking up F's instead of her usual A's. "Nobody ever asked me why," she says. She ended up dropping out and going for a GED instead.

From M. Wilson & A. Houghton (1999). A *Different Kind of Smart: A Study of the Educational Obstacles Confronting Homeless Youth in New England.* New England Network for Child, Youth & Family Services. Reprinted with permission.

Youth who become homeless do not appear to have the opportunity to engage in interactions and activities that foster the development of a sense of industry or competency in their school environments. Homeless youth have been found to have a history of school failure that often dates back to their early school years. One study found that only 44% of homeless youth had attended school regularly before leaving home, 43% had failed or repeated a grade in school, and 11% had failed more than once.

The home environments of homeless youth also do not appear to provide many opportunities for developing a sense of industry or competency. While living at home these youth reported that their parents or caretakers constantly denigrated them, frequently expressed dissatisfaction with them, and spent very little time with them. Once they are homeless, many youth have the opportunity to experience a sense of industry and competency, often for the first time in their lives. Youth who develop the survival skills necessary for life on the streets are able to win recognition from other homeless individuals in the street culture who value those skills. However, because these skills often include shoplifting, stealing, swindling, pickpocketing, prostitution, and begging, they are not consistent with skills valued by mainstream society. Consequently, the sense of competency developed in the context of the street culture may further impede the potential of these youth for becoming integrated into mainstream society. In fact, youth services professionals have reported that the most difficult youth to reach are often those who have achieved the greatest success in adapting to street life.

A Feeling of Connectedness to Others. Interactions that promote development of a sense of connectedness to other people are those in which adults provide social and emotional support to adolescents while permitting them psychological and emotional independence. Interactions in which adults attempt to control adolescents' behaviors by monitoring their activities and applying sanctions in a consistent and caring manner also promote the development of a sense of connectedness because they signal to adolescents that adults care about them and are willing to become involved in their lives.

Research on the family lives of homeless youth prior to leaving home suggests that they have few opportunities to develop a sense of connectedness to parents. Most homeless teens are leaving homes in which they were abused or neglected rather than supported or encouraged. In one study, it was found that 60% of youth in shelters nationwide were physically or sexually abused by parents. Furthermore, the parents of homeless youth, rather than monitoring them in a caring and consistent manner, were found to be excessively strict, use excessive punishment, or be highly neglectful.

Homeless youth lead unstable and hazardous lives.

The lack of connectedness between homeless youth and their families is evident in the fact that parents often knew that their children were leaving home and informed shelter personnel that they did not want their children to return.

Some researchers have suggested that one of the reasons many of these children leave home is to find the connectedness that is missing in their lives—the love and support they did not get at home. In fact, many homeless youth report that they were able to find adults who cared about them while living on the streets. Unfortunately, these adults often exploited them and involved them in criminal activities.

While on the streets, homeless youth also appear to develop a strong sense of connectedness to one another, which offers them a semblance of security and comfort. Street companions often provide the friendship, acceptance, and understanding previously lacking at home or in foster care placements. As difficult as life is on the streets, many homeless youth prefer it to the homes they left.

Although homeless youth may be able to develop a sense of connectedness to other persons, they are not developing a sense of connectedness to society. As a result of years of victimization by parents or other caretakers, homeless youth are mistrustful and fearful of society's institutions and do not believe that these institutions are concerned about their welfare. For that reason, homeless youth typically have not made use of traditional services and community resources. Shelter personnel frequently report that the most difficult task in working with street youth is gaining their trust.

Sense of Control Over One's Fate in Life. Adolescents who have a sense of control over their fate believe that they have some influence over what happens to them. When adults consistently respond to prosocial behaviors with positive sanctions and to misbehaviors with negative sanctions, children learn that their behaviors are related to particular responses. The dysfunctional families of many homeless youth do not provide these kind of responses. Parental substance abuse and family violence often result in parent-child interactions characterized by random responses to children's behaviors. Consequently, children in these families are likely to develop a sense of helplessness rather than control. For many of these youth, leaving home may be a means of trying to gain some control over their fate in life. However, life on the streets does not appear to provide these youth with many opportunities to engage in interactions that foster the development of a sense of control over their lives.

Youth services professionals have reported that the most difficult youth to reach are often those who have achieved the greatest success in adapting to street life.

Sense of Identity. Development of a stable identity has been found to be associated with positive interpersonal relationships, psychological and behavioral stability, and productive adulthood. The development of a stable identity is derived from an adolescent's sense of competency, connectedness to others and to the larger society, and control. Homeless youth are unlikely to have opportunities to engage in interactions that foster the development of these characteristics prior to leaving their homes. Consequently, they are unlikely to have formed the basis for a stable identity before becoming homeless.

The fact that some homeless youth are able to develop a sense of competency with respect to survival skills on the streets and connectedness to others in their street communities may provide a basis for identity development. However, the identity that develops out of this process is likely to reflect alienation from society and identification with the street culture.

Implications for Social Policies and Services

Because homeless youth in the United States tend to come from severely dysfunctional families, they are already at risk for negative development outcomes prior to running away. Although leaving home may be an adaptive response to a threatening situation, those who leave to escape serious family problems often face equally threatening problems on the street.

The prospects for homeless youth making a successful transition from childhood to adulthood are not positive. These youth do not have families that offer guidance, structure, and encouragement; they are isolated from the institutions of society; and although they often develop a sense of connectedness to the street community, that community generally does not provide the assistance and support necessary to foster positive developmental pathways.

One implication for social policies and services is that homeless youth need not only safe places to live, access to education and job training, and physical and mental health services, but also environments in which they can engage in interactions with adults and peers that are productive of positive developmental pathways. Although the youth shelter system offers these kinds of environmental opportunities, the efforts of this system are often impeded by the short time period in which youth can remain in the shelter and by the scarcity of long-term care options for youth. The focus on reunification with families needs to be rethought in the light of the evidence that many of these youth do not have families to which they can return, and many of the families they could return to are likely to be highly dysfunctional.

Altering the developmental pathways or outcomes of homeless youth is not an easy task. A major challenge is that only a small percentage of homeless youth seek assistance from the community agencies that have been established to help them. This suggests that more outreach is needed to contact these youth and provide the services that they need.

Another challenge to helping homeless youth develop along more positive pathways is the absence of advocacy efforts for youth among professional organizations. Developmentalists, long active in advocating services for young children, have not made the same effort on behalf of adolescents. Increased advocacy, as well as increased research efforts by professionals and their organizations, would foster services to help homeless youth develop along more positive pathways.

Jacqueline Smollar, Ph.D. is a Senior Research Associate with James Bell Associates in Arlington, Virginia.

This article is condensed from J. Smollar (1999). Homeless Youth in the United States: Description and Developmental Issues. *New Directions for Child and Adolescent Development*, 85, 47-58. Copyright 1999 by Jossey-Bass Publishers. Used with permission. References are available on our web site (www.TPRonline.org) or in the original article.

Educational Needs of Middle School Homeless Students

By Yvonne Vissing, Ph.D.

The middle school years are perhaps the most stressful for youth, as they begin to transition from being children into adults. The challenges are even greater when one is homeless. Thanks to the philosophy of public education, which seeks to enhance all children's growth and development, school personnel are in ideal roles to assist homeless children and their parents. The purpose of this article is to explore common developmental, educational, and social challenges experienced by homeless children aged nine through thirteen, and to determine how school personnel can develop programs and practices to assist them.

In 1995, the United States Department of Education indicated that 23% of homeless children and youth were not attending school during the time they had no housing. The main reasons included a lack of transportation, transiency in living accommodations, lack of school records, and families' preoccupation with finding food, shelter, and employment.

Developmental Issues

While junior high school once consisted only of seventh and eighth grade, today's middle schools can incorporate grades five through nine. This means that middle schools can teach children as young as nine years old through children fourteen or older. This poses significant challenges for middle school personnel. A nine-year-old child likely still lives within a biological family structure and is too young to negotiate services for him or herself. In this case, the school would need to work with that child's family. But a fourteen-year-old student could be living on his or her own, with other adolescents, or with other people to whom the student has no biological or guardian relationship. Additionally, psychological and physical developments vary widely throughout middle school.

The result of this demographic and developmental diversity is that school personnel must be aware of the wide range of resources that exist in their communities. They need to know details about assisting all types of families who are in economic and housing distress. They need skills on interacting with dependent children and assisting adolescents who are surviving on their own. In any case, whether it is assisting the two-parent family who has fallen on hard times, the single-parent family who is barely making it, the adolescent who is living with friends or acquaintances, or the kid who is surviving on his/her own—the school alone cannot provide all of the needed services. The school is, however, a convenient point for the homeless student and family to enter the community's social service system.

> ***Homeless students are at a disadvantage to produce the same quality work as students who have educational resources at their fingertips.***

The school as point-of-entry into the social service community is dependent upon two critical factors: (1) the knowledge base of the school personnel making the referral, and (2) the range of services accessible within the community. If needed services do not exist, the school can provide the impetus for the community's development of new programs.

Addressing Educational Issues

Traditional classroom structures and educational models of instruction are often counterproductive in assisting homeless students. If schools are dedicated to the proposition that all students have a right to education, and that different types of students have different learning needs and styles, then school personnel must be equally willing to develop programs for homeless students—just as they have programs for other groups of students, such as those who are talented and gifted.

Homeless students have unique challenges and concerns that must be addressed in order for academic and social success to be achieved both in and out of the classroom. Schools must address the social, physical, and emotional needs of the homeless students—otherwise, they will fail in their mission to educate all students. As one New Hampshire principal who worked with homeless students stated when I interviewed him:

> *"We run our schools as if education is the number one priority for all students. The fact is, for many it is not. The fact is, for many kids school shouldn't be their top priority. If they live in homes of chaos and violence, when they don't know what they are going to eat or where they are going to sleep, if they are pregnant or using drugs, or in trouble with their peers—these must be their priorities... Schools must adapt and bend their policies to help the kids, or we are going to lose greater and greater numbers of them."*

Students who have housing difficulties today need not be plagued with their residue tomorrow. Identifying which students have special needs, and addressing those needs, can provide students with the resources for success. Schools can best accomplish this when they are willing to establish a flexible and humane environment where students can prosper, instead of enforcing rigid rules merely for administrative purposes or out of tradition. There are several key areas where schools can develop environments that will benefit the educational process for homeless middle school students.

Flexible Admission Criteria. School policies, procedures, and practices about admission requirements can be punitive to homeless students who, through no fault of their own, are simply unable to provide the necessary documentation. Schools are encouraged to admit students who want to attend their school on a temporary basis, while the school staff works with the student to obtain the necessary paperwork.

Some schools are also establishing working relationships with schools in nearby districts since financially strapped students and parents move to where they can find more affordable housing. This may mean that the community next door has cheaper housing—but is outside the student's school district. If students want to attend their former school, their educational and social continuity could outweigh the administrative benefits of refusing to admit them because they live outside the district.

Flexible Attendance Policies. Schools are encouraged to use greater flexibility when enforcing penalties for poor attendance and tardiness for the homeless. Homeless middle school students seldom have control over the environment in which they stayed the night before. Their parents' situations influence whether or not they can go to school, and many have precarious transportation arrangements. It is common for them to arrive at school late. But when students are penalized for late attendance, it is easier for them to not come at all—because then they can be excused as sick without penalties. Tardy policies frequently create the absenteeism they intend to curb. They are punitive and serve no good purpose for middle school children whose lives are extraordinarily complicated, and who struggle just to get to school.

As one New Hampshire principal told me:

> *"Homeless students are not arriving late because they are blowing off school. These kids are busy fighting for survival. So long as they are coming to school—even late, even infrequently, I haven't lost them... Should I let a bunch of policies that were written for a different type of student get in the way of doing what is right for this kid?"*

Schools are also obligated not to ignore excessive absences or gaps in students' attendance. Instead of having the old-fashioned "truant officer," schools can create positive "absenteeism specialists" who maintain personal contact with homeless students. The absenteeism specialist visits homeless students and their families and addresses obstacles that inhibit school attendance.

Flexible Class Assignments. Homeless students are at a disadvantage to produce the same quality work as students who have home libraries, desks, and other educational resources at their fingertips. Teachers may find homework messy or torn, unaware that it was written on the dashboard of a car—which also served as the kitchen table for the student who lived in it. Homework is often geared for a more stable, middle class student, requiring resources that are unavailable to the homeless. Teachers need to give assignments for which school resources exist so that all students can accomplish the tasks. Non-punitive alternatives could be made available so that all students have the opportunity to learn and succeed.

Homeless students also need plenty of lead time for assignments, since they may be less able than housed students to produce assignments within a limited time frame. Students may have outside jobs with work schedules that interfere with doing homework or studying for a test. They may be asked to watch younger siblings or have to go with parents from place to place after school hours. Just finding a quiet place to do homework may be impossible. Homeless students may certainly benefit from tutors and extra teacher time to assist them with their homework.

Flexible Availability of Resources. Homeless students need constructive places where they can go when they are not in school. Schools that open early and close late provide warm, safe places for students. Schools are positive environments for students to spend time in since there are caring adult role models, extracurricular activities, and educational resources available. When homeless students have had no place to spend the night, they look forward to coming to school early or staying as late as they can. At school they can find locker rooms where they can shower and cafeterias where they can get something to eat.

Libraries can also be wonderful resources. In Baltimore, libraries are matched with shelters to conduct after-school educational support for homeless students. The library programs provide a place for homeless children to study, read, and work on school projects.

Community resources near the school, such as churches, agencies, or public buildings, could open early and stay open late to accommodate students who are in need. These non-school buildings could provide services such as hot meals, recreation, health or social services, and/or educational tutoring.

Flexible Time to Listen. Stigmatization is a significant problem for homeless students. Adolescents prefer to hide their homelessness rather than bring attention to their lack of housing. When they decide to seek help, they will do so only from those whom they trust. Attentive school personnel can identify when the students need special assistance and help them to get to the right service. This is important because homelessness is associated with a host of physical, social, emotional, and educational problems.

Students may need services from mental health professionals, but managed care in mental health has resulted in limiting the number of times a person can be seen. School social workers and nurses do not have that restriction and can see the same child daily during the whole year. Sometimes daily assistance is what it takes to help these make-or-break kids.

Kids in crisis need help immediately, and cannot wait weeks, days, or even hours for help. It takes a great deal of courage for them to ask for help, and when they do, help needs to be delivered in a prompt and sensitive manner. Protection of their confidentiality is important. Students may not come back for help if their confidence is violated.

Flexible Extracurricular Activities. Homeless families do not have extra money to pay for their children's recreational activities. As a result, many schools have attempted to create opportunities for homeless students to be involved in programs that otherwise they could not afford. Much learning occurs outside the confines of the classroom, and extracurricular and recreational programs promote both educational and self-esteem development. Linkages between the school, shelter, and community organizations can facilitate the creation of out-of-school educational and recreational options that benefit homeless students.

Strategies for Greater Inclusion of Homeless Middle School Students

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Improving Peer Awareness. All too frequently there is a fine line between those who are homeless today, and those who were yesterday, or will be tomorrow. In order to support homeless students, and to avoid future negative stereotyping of homeless people, it is important for housed students to understand more about homelessness.

Studies indicate that up to 10% of students in school could be experiencing housing distress within the school year. While most homeless students mask their housing difficulties, they would appreciate it if others were more sensitive to these issues. Homeless students often suffer emotionally from the words and deeds of unthinking classmates.

> ***Homeless students need constructive places where they can go when they are not in school.***

There are curriculum guides such as ones developed by the Minnesota Coalition for the Homeless (www.mnhomelesscoalition.org) and the Pennsylvania Department of Education (ERIC No: ED343969) which provide strategies and information on how to educate middle school students about homelessness.

Students find it helpful to read about homeless children and youth who are their age. A list of recommended books for middle school level students is provided in Table A. School libraries may want to feature the books in a schoolwide homeless education project, perhaps in conjunction with National Hunger and Homelessness Awareness Week.

TABLE A

A Sampling of Middle School Level Books on Homelessness.

Dew Drop Dead: A Sebastian Barth Mystery by James Howe. (January 2000), Aladdin Pub Co.; ISBN: 0689807600. Grades 5-8.

Monkey Island by Paula Fox. (April 1993), Yearling Books; ISBN: 0440407702 . Grades 5-9.

Secret City, USA by Felice Holman, (October 1999) Econo-Clad Books; ISBN: 0785723498. Grades 6-8.

Maniac Magee by Jerry Spinelli, (April 2000) Little Brown & Co.; ISBN: 0316809063. Grades 4-8.

Summary

Middle school children who experience housing distress pose a challenge for school personnel. School personnel must have a keen knowledge of community resources for both families and independent youth in order to meet the needs of this diverse group of students. Schools have the momentary opportunity to cradle vulnerable students in the palm of their hand. The speed and manner in which they do so may determine the students' success trajectory.

Dr. Yvonne Vissing is Professor of Sociology at Salem State College in Salem, Massachusetts. She is the author of *Out of Sight, Out of Mind: Homeless Children and Families in Small Town America.* 1996. Lexington, Kentucky: University Press of Kentucky.

This article is condensed from Y. Vissing (2000). Meeting the educational needs of intermediate and middle school homeless students. In J.H. Stronge and E. Reed-Victor (Eds.), *Educating Homeless Students: Promising Practices* (pp. 45-61). Larchmont, NY: Eye on Education.

Understanding Street Culture: A Prevention Perspective

By Jerry Fest

Perhaps the greatest challenge we've faced as a nation in dealing with youth homelessness is recognizing the nature of the work that we are doing. In our efforts to secure funding and come to terms with the complexity of issues we often are led by our terminology. Labels such as "homeless" and "at-risk" youth guide our interventions through socio-economic or environmental filters. If the problem is that they are homeless, then the solution is to find them a home. If they are at-risk, then we alter their environment to remove or minimize the risk.

The problem is that being "on the streets" is not a socio-economic condition or environmental circumstance. It is a way of thinking about yourself and your relationship to the world. It is identification with a defined culture that is separate and distinct from the dominant culture of adults. Recognizing the cultural environment in which homeless youth live is the key to successful interventions with this population. Understanding that you are doing cross-cultural work when reaching out to homeless youth is the most important prerequisite for successful outcomes.

The Culture of the Streets

In my work with homeless youth I have received quite an education on the culture of the streets. "Street Culture" is not a catch-phrase or an interesting way of looking at street-related issues. Rather, it is a definable culture that is every bit as real as any other culture you'll encounter. What is it that defines a culture? A culture will have beliefs, values, and principles that are shared by the culture's members. It will have defined patterns of behaviors and mores, a "code of conduct" that governs how things are done with distinct taboos and political do's and don'ts. There will be a sense of history with often-told stories, traditions, and ethical standards. All of these things exist for young people on the streets in such an identifiable form that I have been able to compile a description for use by youth workers in a manual titled *Street Culture: An epistemology of street-dependent youth.*

When the culture of the streets is defined and programs realize that the nature of their work is cross-cultural, it changes the focus of the services we offer. The most important factor in helping youth transition out of street life lies not in meeting basic physical needs (food, clothing, shelter, etc.), it lies in addressing conceptual needs. The "streets" aren't under a youth's feet, they're under a youth's scalp. Unless we reach out with a cross-cultural awareness and address conceptual needs, we can provide all the food, clothing, and shelter money can by, but we are unlikely to see any significant behavioral changes.

The culture of the streets is a factor in youth homelessness that is so defined as to be universal. While regional differences exist, programs across the United States, as well as programs in other parts of the world such as Norway, Guam, Australia, Israel, Turkey, and South Korea find the information in *Street Culture* applicable to the homeless youth they serve. The reason is that while national cultures may be vastly different, the life experiences of youth on the streets are strikingly similar. Take for example the following quotes from an article in a Portland, Oregon newspaper, written about a shelter for runaway girls:

- "Girls fleeing brutal homes find a haven that helps them avoid lives of drugs, crime and prostitution."
- "For years, (we) chose to ignore the problem of… runaway youth. But as more and more children have taken to the streets—and fallen prey to prostitution, crime and addiction to cheap and plentiful heroin—(we've) had no choice but to act."
- "Divorce, addiction, poverty and the bizarre demands of parents are the main causes of runaways," said the 30-year-old manager of… the shelter… "There are parents who force their children to steal money for their heroin addiction. There are parents who brutally beat their children."
- "We don't want to leave them on the streets because they'll end up as prostitutes… We are making a long-term investment (in) these girls."

These quotes could come from a description of any shelter anywhere in the United States. The title of the article, however, was "Shelter Serves as Lone Escape for Abused Iranian Runaways." The shelter is located in Tehran, Iran.

> ***Understanding that you are doing cross-cultural work when reaching out to homeless youth is the most important prerequisite for successful outcomes.***

While recognizing the dynamics of street culture has important application to intervention efforts, it also gives us valuable insight into prevention efforts. This prevention element may even be more important since the problem with intervention is that it's not useful until youth are already on the streets. The question becomes what can street culture teach us that will help us prevent youth from ending up on the streets in the first place? The first lesson may be a somewhat controversial assertion.

There Are Elements of Choice in Street Involvement

It is far easier for adult helpers to see youth on the streets as victims of circumstances beyond their control. To a great extent that may be true. The childhood abuse and neglect that most have experienced was neither under their control, nor are they in any way responsible for it. But while we often have neither control over—nor choices about—the circumstances of our lives, we do have control over how we respond to those circumstances.

Psychologist Nathanial Brandon tells the story of two sons of an alcoholic father—one who became an alcoholic himself, the other who did not. When asked separately why they did or did not drink, both sons gave the same response—"that's easy, I grew up watching my father." While they both had the same childhood circumstances, they responded to those circumstances in dramatically different ways.

This helps to explain why "cause and effect" research statistics have not been very helpful in prevention efforts. Most programs will support statistics that show 80% or more of juveniles involved in prostitution were sexually abused as children. What these statistics don't tell us is why the other 20% are out there, and why there are vastly greater numbers of sexually abused children who do not become involved in street prostitution. Yes, we are products of our environments, but we are conscious products of these environments and we make choices. Our choices will naturally be strongly impacted by our life experience and the options we perceive as available to us, but they will be choices nonetheless.

We do street youth a disservice when we see them as hapless victims. They have been and continue to be victimized in their lives, but a "victim" does not survive on the streets. If we fail to recognize the role that choice plays in their street involvement, then we will fail to utilize their ability to make different choices, and fail to come up with viable alternatives to the choices they are making. Even more important, we will continue to fail in our efforts to prevent young people from making the choice to become street-involved in the first place.

Why Youth Choose the Streets

If we accept that becoming street-involved involves a level of choice, then the question becomes what is the attraction of that choice? The reality of life on the streets is not a pleasant one. It is a violent and unglamorous world of drugs and prostitution. It is a daily struggle for survival—often survival in a literal sense—where you are cold and hungry far more often than you are comfortable. You are living outside of society and the law with little future and a present filled with fear. It is a lifestyle that I once heard described as endless hours of excruciating boredom punctuated by moments of extreme terror. Why would anyone choose this?

The answer can be found in what the culture of the streets offers in a developmental sense. All young people experience a natural process of development where they are seeking ways to meet their basic physical and social needs. These needs include developing a sense of connection and commitment to others, a sense of belonging, and a perception that one has some control over their life. Youth who have had the benefit of a healthy childhood and the support of a stable and loving family are able to meet these developmental needs through traditional structures and outlets. Young people with histories such as those experienced by most street youth, however, find that traditional structures often fail in meeting these developmental needs. They have not been able to develop healthy bonds within their family systems, and their life experience has often distanced them from their peers, and created issues and behaviors that label them within traditional structures. The attraction that street culture offers is an environment where they can succeed, where they are accepted, and where they can feel some measure of control over their lives.

> ***Help from others was a critical factor in being able to resolve problems they faced.***

Prevention Implications

Youth choose life on the streets because they perceive it as their best option for pursuing developmental needs. To prevent that choice we need to examine why traditional structures such as family and school fail to be viewed as a more viable option. When we look at the histories of abuse and neglect that most street-dependent youth have endured it is often easy to see where the family fails in this respect. What is more difficult to understand is how other systems are failing to meet these needs. We should examine the effect that traditional systems may have on the choices young people make by taking a look at two other "Effects."

CASE STUDY – ROBBIE

Robbie was 17 when he decided to drop out of school and get a job. His father agreed to let him go on living at home for $80 a week. But when Robbie decided to re-enroll in school and couldn't keep up the payments anymore, his father kicked him out. In October he pulled into the driveway of a local social services agency, in the beat-up car where he had been living for two months. Though he was enrolled in school full-time, he didn't have an alarm clock to help him get up in the morning, and he was often late. He had a small income from his part-time job, but he could hardly feed himself. If he was going to continue in school, he clearly needed the basics: housing, food, clothes and regular access to a shower. The agency helped him find a cheap apartment, bought him shampoo, toothpaste, school supplies and other necessities, helped him sign up for free breakfast and lunch at school, and directed him to the local soup kitchen. It negotiated with the school to reduce his class schedule so that he could continue to work, and provided him with tutoring, a particularly urgent need because Robbie had been diagnosed with learning disabilities and was considered academically limited.

From M. Wilson & A. Houghton. (1999). *A Different Kind of Smart: A Study of the Educational Obstacles Confronting Homeless Youth in New England.* New England Network for Child, Youth & Family Services. Reprinted with permission.

The Hawthorne Effect

From 1927 to 1932, Harvard Business School professor Elton Mayo conducted studies intended to compare productivity and work conditions. Six women were selected from an assembly line to participate in the study, which involved frequent changes in their working conditions. Rest breaks were lengthened and shortened, added and dropped. Work hours were extended and reduced, and various other changes were tried. The confusing result of the study was that throughout all of these changes productivity steadily increased. There was no correlation to positive or negative changes, only a steady increase in productivity.

As it turned out there was a factor entirely different from working condition changes that was responsible for the increase in productivity. The six women who were selected for the experiment were participating of their own free will and were dealt with as cooperative partners in the study. They became a team with a shared sense of responsibility for the outcome. It was this sense of involvement and participation in the study that increased productivity, not the arbitrary changes in working conditions. Even when working conditions were made worse than what they were used to, such as working a full day without any breaks, medical checks showed no signs of cumulative fatigue and absence from work declined by 80 percent.

This has become known as the Hawthorne Effect. People are happier and function better in environments where they are active participants in the decisions that impact their lives, even if other environments may be "better."

The Pygmalion Effect

Many teachers are already familiar with the Pygmalion Effect from the book by Robert Rosenthal and Lenore Jacobson, *Pygmalion in the Classroom* (Holt, Rinehart and Winston, 1968). In a classic experiment, Rosenthal and Jacobson randomly picked 20% of the children in 18 elementary school classrooms. The teachers were told that these children were "intellectual bloomers" who could be expected to show remarkable progress during the year. The result was that in the three measured areas of verbal ability, reasoning, and overall IQ, these randomly selected youth all showed gains greater than the rest of the class. Why? Because that's what the teachers believed and expected.

The Pygmalion Effect is that people tend to conform to our beliefs and expectations of them. If we expect young people to be achievers and contributors, we work with achievers and contributors. If we expect young people to be troublemakers and problems, we work with troublemakers and problems.

Resiliency Research and Protective Factors

Research into human resiliency has found that overcoming challenges and difficult circumstances is an innate human quality that can be nurtured through specific methods of interaction. These methods, identified as "Protective Factors" by researchers, can be summarized as three broad approaches:

1. Caring and supportive relationships
2. High expectations
3. Opportunities for participation

Resiliency research correlates with the two "Effects" described in this article. The Hawthorne Effect demonstrates that opportunity for participation increases satisfaction and functioning. The Pygmalion Effect demonstrates that people respond to high expectations. Both of these "Effects" are best nurtured within the context of caring and supportive relationships. But it is precisely these three protective factors that are often missing in a young person's life as they make choices that lead them to the streets. Rather than being involved in choices and decisions that concern them, they are more often mandated to various treatments and interventions as systems attempt to correct their "problems." Their behaviors are often disruptive and difficult for adults to deal with, lowering our expectations of them and leading us to see them through negative labels (manipulative, aggressive, etc.). Caring and supportive relationships become the exception in their lives, replaced by authoritarian and frustrated responses from the adults they know. Our responses become part of a self-fulfilling prophecy about their potential, and the culture of the streets begins to be perceived as a more attractive option to them. If we want to intervene and successfully prevent youth from becoming involved in the culture of the streets, we must focus on our behavior at least as much as we focus on the behavior of young people. It is the youth who challenge us who are on their way to street involvement. Do we respond by attempting to control their behavior, or do we reach out and include them in the solutions we seek? Do we see them as "problems" and lower our expectations of them, or do we see them as resources and expect that they can be successful? Prevention may truly be as simple—and as difficult—as what we believe about young people, and how far we are willing to go to work "with" them, rather than "at" them.

CASE STUDY – TASHA

An emancipated minor who was homeless before eventually moving into her own apartment, Tasha hated going to school with students who led the kind of middle-class, sheltered life she never had. "We're a different kind of smart," she said, glancing around the group of teenagers camped out on the floor and on sofas in an upstairs room of an agency's outreach center. "There's street-smart, and there's common sense smart, and a lot of people in school, they just don't have it. They may get it when they're older, but you can tell by listening to them flap their gums that they don't have it now. And it just burns me I had to be with them." It also made her angry that school officials didn't trust her enough to let her call herself in sick, even though the state considered her an adult. Like many homeless youth, she says her school was unwilling to recognize her problems as fundamentally more serious than the problems of most high school kids. "They want to know why I'm late to school and I'm like, 'Okay, the toilet in my apartment was overflowing, alright?' And they just look at you."

From M. Wilson & A. Houghton. (1999). *A Different Kind of Smart: A Study of the Educational Obstacles Confronting Homeless Youth in New England.* New England Network for Child, Youth & Family Services. Reprinted with permission.

It is said that young people are our future. I don't think that's entirely accurate. Young people are a mirror of our present. If we don't like what we see, the change needs to begin with us. ⁓

Jerry Fest is the author of *Street Culture: an Epistemology of Street-dependent Youth.* He has been advocating for street-dependent young people since 1970. He is the founder and worked 12 years as the director of Janus Youth Program's Willamette Bridge. Mr. Fest can be reached at jtfest@in4y.com or (503) 231 3947.

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The McKinney Act's Education for Homeless Children and Youth Program

By Melanie Wilson, M.S.W. and Alison Houghton, M.S.W.

In response to the growing social and political recognition of problems associated with homelessness, Congress passed the Stewart B. McKinney Homeless Assistance Act in 1987, a portion of which established the Education of Homeless Children and Youth (EHCY) program. McKinney (recently renamed McKinney-Vento) affirmed that homeless children and youth have the same right to a free, appropriate public education as other students, but recognized that, due to a variety of obstacles—including residency and guardianship requirements and the availability of health and academic records—they were often unable to access and succeed in school. The new law required states to lower such barriers so that homeless children and youth could successfully participate in school. It also established formula grants to the states to fund programming for homeless students in particularly needy districts. The law's definition of homelessness was broad, and for the purposes of the EHCY program, was interpreted by the U.S. Department of Education to include runaway, "thrown away," and abandoned children and youth, including those living in any shelter or transitional setting. Even children and youth living with friends could, depending on their circumstances, be considered homeless. Children in foster care, however, were excluded, unless they were in temporary emergency placements due to lack of foster homes.

To administer the grant program, provide education and technical assistance to schools, and generally assist states in carrying out the provisions of the EHCY, the law also established the office of EHCY state coordinator.

The McKinney Act has generally been considered a success. A recent evaluation of the EHCY program finds that almost all states have revised school policies regarding homeless children and youth, and that as a consequence attendance rates for homeless students have risen from 50% in 1987 to 86% in 1995. State coordinators themselves say that issues such as residency requirements and lack of previous school records are now minor barriers for homeless students.

Although the McKinney Act and its subsequent revisions have been well-intentioned, homeless students still face serious obstacles to finishing school. The most frequently cited barriers for such students are now guardianship and immunization requirements, transportation problems, and school fees. Poor health and an inability to obtain adequate food, clothes, and school supplies are also cited as continued areas for concern, along with the inaccessibility of special education evaluation and placement, the difficulties surrounding participation in after-school events and activities, and the lack of available counseling and psychological services.

But another issue at least as important is one that school and state officials do not report: the behavior problems and learning disabilities that make many homeless youth undesirable students and that can prompt overburdened schools to reject them if a legitimate way can be found. While bias against potentially difficult students, especially when they come from out-of-district, is sometimes understandable, it is probably the most pervasive problem homeless students face, and the one hardest to regulate.

Youth in particular face "extreme barriers to success," according to the 1995 EHCY evaluation commissioned by U.S. Federal Department of Education. Fear of aggressive teenagers has prompted some schools to reject homeless youth as liability problems, and even McKinney-funded districts have developed few academic support programs for teenagers. Recent episodes of school violence will presumably make schools even more reluctant to accept troubled adolescents.

Homeless students still face serious obstacles to finishing school.

The shortcomings of McKinney's EHCY program are magnified by the extremely limited funds appropriated to implement it. Though Congress authorized $50 million for EHCY in 1990, the program has never been fully funded; in 1998 Congress appropriated just $28 million, the same level as four years earlier. The appropriation rose to $35 million in 2001, still considerably short of the level of support envisioned by Congress. Congress' lack of investment in the EHCY program has profound implications. A mere 3% of all local educational agencies in the United States receive McKinney funds, and of those, most receive no more than $60,000 a year.

For adolescents who live outside of McKinney-funded districts in New England, there is little evidence that McKinney, which is supposed to lower barriers to school enrollment and attendance in all districts, has had a beneficial impact on educational chances or experiences.

(McKinney's EHCY program is currently being reauthorized by Congress. Homelessness advocates are hopeful that the new law will be strengthened to give homeless students the right to immediate enrollment in school, and the right to remain in their schools of origin.)

This article is excerpted from M. Wilson & A. Houghton. (1999). *A Different Kind of Smart: A Study of the Educational Obstacles Confronting Homeless Youth in New England.* New England Network for Child, Youth & Family Services. Reprinted with permission. The complete report is available from New England Network, 25 Stow Road, Boxboro, MA 01719.

Helping Homeless Youth Help Themselves: Exploring the Roles of Professionals

By Sara V. Jarvis, Ph.D., Elizabeth W. Lindsey, Ph.D., and Nancy R. Williams, Ph.D.

Increasing numbers of runaway and homeless youth have posed a serious challenge for policy makers, educators, human services providers, and communities. While research has documented the reasons youth run and the challenges and risks they face while separated from their families, there has been little attention paid to how these youth are able to emerge from homelessness and create a measure of success in their lives. This article summarizes some of the findings from a study which explored how runaway and homeless youth make successful developmental transitions into adulthood.

Methods

Team members conducted conversational interviews, ranging from 50 to 90 minutes each, with 12 formerly runaway and homeless youth. An interview guide, developed with input from youth peer educators and youth service providers, provided the framework for the conversation. Criteria for participation in the study were that participants be between the ages of 18-25 and that they had stayed in a youth shelter, group home, or other alternative living arrangement as an adolescent, but not within the past two years.

The interviews were tape-recorded, transcribed and analyzed using the constant comparative method. This method involves analyzing data as it is collected, using preliminary findings to shape future interviews, and seeks to build a conceptual framework that reflects participant experiences and perceptions regarding the research question.

Findings

This article focuses on two major findings from the research: (1) what youth had learned about successfully moving toward adulthood and how they learned it, and (2) what types of help and helpers they saw as most effective in their lives.

• Learning New Attitudes and Behaviors

All 12 participants reported that learning new attitudes and behaviors helped them deal more effectively with turning points and difficult times, although the nature of the attitudes and behaviors they learned varied. The concept of learning encompasses both *what* youth learned and *the process* by which the learning took place.

What Youth Learned. The attitudes and behaviors youth perceived to be most important seemed to fall into two general categories: what they learned about themselves and what they learned about being in relationships with other people.

Learning about themselves encompassed such ideas as the development of self-confidence, learning to accept and love themselves, learning to take care of themselves, and the importance of personal goals. Learning about being in relationships with others centered on learning how to be more considerate, responsible, and careful in relating to other people. This area of learning involved such lessons as: taking responsibility for their own actions, learning to get along with others, learning to trust others and accept help, becoming better judges of character and avoiding bad influences, and helping others.

How Youth Learned. All 12 participants reported learning from their own mistakes and experiences. Several of these young people noted that, for them, making such mistakes was unavoidable. For some young people, the learning process occurred very quickly, as a dramatic event alerted them to the potential consequences of their actions. For other youth, the learning process was more gradual, involving observation over time that the ways they were handling certain situations were not working very well.

While all 12 participants indicated they had learned from their own experiences, three youth also said that they had learned from the experiences and mistakes of other people, usually friends or family members. Another participant talked about more positive learning from others, seeing other young people who were doing well as possible role models for herself.

> ***Help from others was a critical factor in being able to resolve problems they faced.***

The pace of learning differed both between and within individuals. Sometimes learning took place very quickly. Sometimes learning took place more gradually, as youth reflected back over various experiences and came to the conclusion that certain types of attitudes and behaviors were not working for them.

• Help from Others

All the participants indicated that help from others was a critical factor in being able to resolve problems they faced. They identified types of help, types of helpers, conditions that facilitated help, and offered advice for professional helpers.

Types of Help. Participants identified four types of help they perceived as important: caring, setting boundaries and being held accountable, concrete assistance, and professional intervention. Eleven participants talked about being cared for by others. This did not involve trying to cure or solve their problems. Instead, *caring* entailed individualized attention, unconditional acceptance, nonjudgmental listening, and emotional support and was expressed by such phrases as: "being there for me;" "being available when I need her;" "letting me make tough decisions, but guiding me;" and "treating me like I was her own." Ten of the participants spoke about the importance of family and professional helpers who "talked straight" to them, challenged them, *held them accountable* for their actions, confronted them with the consequences of their actions, and set boundaries. *Concrete assistance* took many forms such as: sheltered living, living with a relative, groceries to support the family when parents had abandoned them, medication to treat mental illness, and money for school. *Professional intervention* included a wide range of interventions including conversations with shelter staff, formal counseling or therapy, and full-scale residential treatment. Seven participants credited some form of professional intervention with helping them resolve problems and get their lives back on track.

Types of Helpers. All 12 youth talked about the role their *families* played in their adolescent years. At times the families were helpful such as when they served as sources of caring and support at critical junctures in the youths lives. However, many of the youth had volatile histories with their families and found they needed to separate from them in order to stabilize their lives. Three quarters of those interviewed commented on the importance of *friends*, some of them long-term friends, and others more recent acquaintances.

All but one participant mentioned working with professional helpers. Some professional helpers had formal degrees in fields such as education, social work and psychology, but the practice of many helpers was based on their life experiences rather than on formal education. Professionals perceived as helpful were caring, but also held youth accountable for their actions. Sometimes youth resented helpers' strict rules at the time, but in retrospect saw their value. For many youth, these helpers were a primary constant in lives filled with change and confusion. A number of youth identified teachers, counselors, and foster parents who went beyond their assigned roles in reaching out to youth. Not all professionals were seen as helpful, however. Those who were not helpful were described as uncaring, uninvolved, and manipulating clients to make their jobs easier.

Conditions Facilitating Acceptance of Help. Youth indicated that two conditions had to be present for them to utilize the help offered them: they had to perceive the helper as trustworthy and they had to be ready to accept help. *Trustworthiness* involved: insuring continuity of care, honoring confidentiality, treating youth as whole persons rather than labeling them, and keeping promises made to youth.

The youth's own *readiness to accept help* was also a key factor. Some felt they had to make mistakes before they could realize they needed help. Rather than being able to learn from observing peers who got into trouble or learn from advice they were given, they had to try out risky behaviors for themselves. For others, it was necessary to hit rock bottom before opening to assistance. Sometimes readiness was precipitated by a frightening or traumatic event such as fear of losing custody of a child, parents' divorce, abuse, arrest, or time in jail.

• Advice for Professional Helpers

Participants had a number of specific suggestions for professional helpers of runaway and homeless youth:

- *Keep your promises.* These youth had experienced a great deal of turmoil and instability in their lives. When they take the risk to form a relationship with a helper they need to know they can count on that person, that promises will be kept.
- *Create a safe space in which youth can learn to trust.* Many participants were distrustful or had never learned to trust others. A safe space—one in which youth could join with others, could count on being listened to, could be assured of others' honesty, and could safely surface deeply personal issues—provides a context for learning to trust.
- *Listen to and accept youth.* Helpers need not have had the same experiences, but must try to put themselves in the youths' shoes. Helpers need to accept the fact that "teenagers are going to try things at least once" and not reject youth who take unwise risks.
- *Develop personal relationships.* Most of the participants felt that the professionals who were most helpful were those who developed personal relationships rather than maintaining rigid helper-client boundaries. In some cases youth came to view the helpers as friends.
- *Don't pity youth.* Several youth talked about the importance of helpers being strict and holding youth accountable. As one youth put it, "Don't feel sorry for me to help me out… pity is just the worst thing. Boost me along the way, but don't pity me. It makes me feel helpless."

Discussion and Implications for Service Providers

Youths' ability to learn from their difficult experiences seems to be one of the primary factors in successful transitions. As they came to understand themselves better, including what was important to them, they also began to accept and value themselves in new ways. In the process, they developed more self-confidence and learned how to take better care of themselves, to take responsibility for their actions, to discriminate between people who were good and bad influences in their lives, to clarify what was important to them, and to trust potential helpers. They also learned specific skills for interacting with other people in more constructive ways.

> ***Youth indicated that two conditions had to be present for them to utilize the help offered them: they had to perceive the helper as trustworthy and they had to be ready to accept help.***

The young people in this study indicated that recognizing their own value was an important first step in making significant changes. A strength-based approach to practice with this population would seem to be most appropriate. However, such an approach is a challenge within problem-oriented systems of care that identify young people by their criminal behavior, psychological disturbance, school performance problems, and other forms of social dysfunction. One way that professionals can help young people begin to take this first important step is to identify existing strengths and resources, both for the youth and for people who are involved with the youth. The assessment process should focus on strengths as well as on problems to be addressed. Professionals can then help youth build on and enhance existing resources and learn new approaches to problem-solving and self-care behaviors.

An alternative to viewing runaway and homeless youth as dysfunctional is to recognize their life experiences that have prepared them to survive and eventually, perhaps, even to thrive. Such experiences may be conceptualized as meeting challenges presented by life rather than as evidence of social dysfunction. Rather than seeing runaway and homeless youth as victims or impaired in some way, professionals can help young people identify survival strengths within themselves and recognize and develop the qualities that will be of benefit to them in the future.

Although the process through which participants' learning occurred varied somewhat, all youth reported that they had learned from their own experience. Youth have to be able to see a real connection between potential consequences and their own lives. Unless they are able to make that connection, such consequences may have little meaning for them. An implication of this finding is that parents and professionals who work with at-risk youth must realize that, despite all the primary prevention measures at their disposal, some youth will have to learn through their own experience of making mistakes and getting into trouble. This phenomenon supports the need for early intervention programs that work with young people once they get into trouble, but without branding them as "troublemakers."

Learning for these youth was a developmental process during which there were periods of accelerated learning, but also periods in which readiness for learning may have been developing, but was perhaps still in process. Among youth in this study, change was not a linear process, but one characterized by cycles of progress and regress. Because of the unpredictable and somewhat fitful nature of this learning process, professional helpers may at times find working with runaway and homeless youth to be frustrating or discouraging. Although it may be difficult to recognize when learning or other change is happening, it is important that helpers maintain a focus on the possibilities for learning in any situation, whether in the present or the past. When helping youth address a current situation, helpers might focus on what can be learned from a poor decision or ineffective problem solving. In reflecting on the past, professionals can help youth reframe the meaning they attribute to seemingly negative experiences by helping them identify important learning.

> ***The young people in this study indicated that recognizing their own value was an important first step in making significant changes.***

Family and friends are key players in youths' lives, and relationships with them are dynamic and ever-changing. Family members from whom youth are currently estranged may, in the future, become supporters. Friends who may now serve only as bad examples may offer important lessons about the possible consequences of certain actions. Helpers must take care to avoid discounting or diminishing these important players in a youth's life. Instead, they can support the youth's development of healthy relationships and assist in their understanding and learning from the dysfunctional dynamics that may exist.

Our research participants perceived professionals who engaged with youth as persons rather than as clients as most helpful. These individuals allowed the relationship to transcend fixed helper-client boundaries, often developing caring relationships that extended beyond the youth's involvement with a specific agency. In these relationships, youth felt they were seen as whole persons, were valued for who they were, and were truly cared for by the helper. This is not to suggest that helpers should violate professional ethics in their involvement with youth. Rather, it is to highlight the deeply felt need of these youth to be cared for and appreciated as persons in their own right and to challenge professionals to find their own best paths toward such caring relationships with youth.

Assisting runaway and homeless youth in successfully managing the transition to adulthood is a challenging prospect for professionals. There is no one right approach, no one intervention that will guarantee success. Instead, there are many right ways—and they are all grounded in an authentic human connection that is focused on genuine caring, mutual respect, enduring patience, and a willingness to work together to create a safe space for learning from the experiences life brings.

Sara V. Jarvis, Ph.D. is a private consultant. Elizabeth W. Lindsey, Ph.D. is with the Department of Social Work at the University of North Carolina at Greensboro. Nancy R. Williams, Ph.D. is with the School of Social Work at the University of Georgia.

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WEB RESOURCES

Illinois' Opening Doors Program
www.lth3.k12.il.us/openingdoors

Opening Doors is an Illinois State Board of Education project funded by the Stewart B. McKinney Homeless Children and Youth Program. This site is intended to disseminate information about the educational rights and needs of homeless youth. Under the "Just for Schools" link are a number of resources for principals, teachers, support staff, and others. These include such items as "Tips for identifying homeless children and youth," "Do you have homeless children in your classroom?" and "What a school nurse can do to help homeless students."

National Coalition for the Homeless
www.nationalhomeless.org

The National Coalition for the Homeless is a national advocacy network committed to ending homelessness. This web site includes a number of fact sheets, including "Education of Homeless Children and Youth," "Homeless Youth," "The McKinney Act," and "Homeless Families with Children." Additionally, they have fact sheets on rural homelessness, domestic violence, mental illnesses, and health care, among others. This web site also includes a directory of national, state and local homeless organizations, information on educational issues, links to other resources, and several publications available at a cost.

Texas Office for the Education of Homeless Children and Youth
www.tenet.edu/OEHCY/

A unique feature of this site is the "Campus Self-Assessment Guide" which is a self-assessment tool designed to help schools determine the adequacy of their current services to students in homeless situations. This guide is available under the "publications" link on the home page.

Rural & Urban Runaways: Different Survival Strategies or Different Resources?

By Lisa E. Thrane, M.S. and Kevin A. Yoder, M.S.

To date, there has not been a systematic investigation of size-of-place differences associated with runaway behavior. Little is known about youth who run away from rural areas and few comparisons have been made to their urban counterparts. This article examines whether rural runaways leave home at different ages and for different reasons than urban youth. It will also investigate whether city size influences the use of deviant subsistence strategies and the rate of street victimization.

This article is based on interviews with 599 runaway and homeless adolescents in shelter facilities and drop-in centers as well as directly on the street in Missouri, Iowa, Nebraska, and Kansas. Participation was voluntary and could be terminated at any time. Interviewers were required to report child maltreatment. Rural runaways, who came from communities of not more than 2,500 people or who lived nearby in the country or on farms, comprised 7% of the sample (N=42) with the remaining 93% (N=557) consisting of urban adolescents. As Table 1 indicates, 76% of rural youth were surveyed in metropolitan shelter facilities; in contrast, 93% of urban adolescents were. The vast majority of shelter sites were in metropolitan cities, which underscores the under-representation of rural runaways in the sample.

TABLE 1

Shelter Location Interviewed

Rural Youth (N=42)	N	%
Interviewed in Non-metropolitan Shelter	10	24%
Interviewed in Metropolitan Shelter	32	76%
Urban Youth (N=557)	**N**	**%**
Interviewed in Non-metropolitan Shelter	41	7%
Interviewed in Metropolitan Shelter	516	93%

City size of first run did not play a role in youth's initial decisions to run away. Mean age at initial runaway was not significantly different for urban and rural youth (13.5; 14.1, respectively). Although rural runaways tended to run later as the level of physical abuse increased, abuse had little influence on urban youth's first runs. At higher rates of physical abuse, rural adolescents delayed running nearly a year and a half compared to their urban counterparts. Rural areas in the Midwest are generally facing a deteriorating economy. Therefore, the authors speculate that rural environments offer fewer options for adolescents trapped in abusive familial relationships. Many rural areas lack shelters and resources to assist this vulnerable population. It would seem that, as rural youth consider running away from abusive families, they realize that their communities do not provide viable options for them to escape. Being returned to an abusive home through an inhospitable community structure may prove more costly than waiting until rural runaways find a way to survive on their own.

According to Conger and colleagues, rural conditions have set the stage for social and psychological difficulties for rural families. An outcome of community disadvantage was less attachment among neighbors and less monitoring of adolescent groups in small Midwestern cities, as noted by Simons and others. Based upon the literature, the authors suggest that physical abuse may sever rural adolescents' social ties. Weak social networks and the lack of social welfare programs for rural youth could reduce the potential benefit of running. Rural adolescents remain in abusive homes longer to minimize costs. This indicates that rural communities make running in the short-term a less feasible option for physically abused youth.

> ***At higher rates of physical abuse, rural adolescents delayed running nearly a year and a half compared to their urban counterparts.***

The use of deviant means of support did not differ across rural or urban youth. However, in the context of physical abuse and age at first run, means of support differed markedly for rural and urban adolescents. Physical abuse had little bearing on urban adolescents' survival via the street economy, but rural youth were more embedded in deviant subsistence when they had suffered higher rates of physical abuse. One explanation for this finding is abuse removes access to friendships and much-needed resources from home, which decrease the options available to rural runaways. Abuse could eliminate legitimate social networks for rural youth more effectively than for urban runaways, thus making the street economy their only means of survival. Abused rural youth may view deviance as a practical option to realize their immediate needs. Having been subjected to abusive familial relations over a longer period of time might blunt the emotions and make rural youth shrewder in their calculation of rewards to costs. Satisfying their basic needs (i.e., food, shelter) may be more valuable in the short-term than the risks associated with theft, drug sales, or prostitution.

The use of the illegitimate economy was fairly stable for urban youth regardless of the age that they found themselves on their own. This was not so for rural adolescents. Rural youth became less involved in deviant means of survival as age at first run increased. One possible explanation might be that survival initially necessitates the use of the street economy because their family difficulties have isolated them from community members who would have shielded them from the street. Without these ties, few legitimate options exist for younger rural adolescents who have run away. Older rural runaways may be more adept at penetrating the street network to find institutions specifically geared to their needs; in addition, age gives them access to legitimate means of support. This could account for some of the differences observed because shelters and drop-in centers provide much needed resources that reduce runaways' reliance on deviant subsistence strategies.

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Rural & Urban Runaways

The final hazard for runaways is street victimization. In predicting the rate of street victimization, city size had no effect. Street victimization is one of the costs that both rural and urban runaways pay for living on their own or directly on the street. They are continually exposed to dangerous places and motivated offenders—a high cost to escape maladaptive familial relations.

In conclusion, our results indicate that rural youth remained in physically abusive homes a year and a half longer than urban adolescents who suffered similar levels of abuse. They may do so because of the lack of social services available in rural communities. Rural adolescents used more deviance to "get by" on the street if they suffered higher rates of physical abuse or were younger when they ran away. Deviant subsistence, in and of itself, places youth at increased risk for street victimization. Once they were on their own, victimization rates of both rural and urban adolescents were comparable, suggesting that the street exacts its own justice.

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For more information about this research see L.Thrane, D. Hoyt, L.Whitbeck, and K.Yoder (Under Review). Comparing rural and urban runaway and homeless adolescents: Age at first run, deviant subsistence strategies, and street victimization. And L. Whitbeck, & D. Hoyt (1999). *No Where to Grow: Homeless and Runaway Adolescents and Their Families.* New York: Aldine de Gruyter.

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Case Study – Josie

Josie, a 17-year-old with a history of extreme abuse, both by her biological parents and then later by foster parents, has been hospitalized for borderline personality disorder and bipolar disorder four times in the last year. She is, however, a bright and motivated student, and her most ardent wish is to find a way to finish school. Given her tangled academic history, though, she may never achieve her goal. Her most recent trouble with school began in 1998 when, while attending a vocational high school, she was hospitalized. Later, she was notified by the school that she had missed so much class that she could not return to the program. She then enrolled in a regular high school; still in the hospital, she never set foot in the door, but instead put together a sort of correspondence course for herself whereby teachers sent her homework, which she then completed and returned. Later the school said she hadn't done enough work to receive full credit. Meanwhile she had moved to a Department of Mental Health-funded residential program, where she tried to enroll in yet another school. But the school refused to take her on the grounds that she would be at the agency only a short time, and that she was still technically enrolled in her previous school. The problems went unresolved, and the school year eventually ended. Thus, Josie faced a long summer of waiting, with no guarantee of school in the fall. "No one wants to take responsibility for me," she said. "I've been to eight or nine schools, and it's hard, because you lose your trust after a while. You go through so many, it's like a blur. I just want to graduate with my class." Her caseworker underscores the importance of school to Josie: "It's one of the things that keeps her alive," she said.

From M. Wilson & A. Houghton. (1999). *A Different Kind of Smart: A Study of the Educational Obstacles Confronting Homeless Youth in New England.* New England Network for Child, Youth & Family Services. Reprinted with permission.

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Recognizing Teenage Depression

By Karen L. Swartz, M.D.

With at least 5% of teenagers experiencing an episode of major depression, this medical condition is very common. As depression is a potentially lethal illness, it is critical that everyone become educated about the symptoms. Throughout this article, a series of commonly asked questions about teenage depression will be posed and answered.

Is feeling sad always a sign of a serious depression?

The word depression can have many meanings. If asked, most people would say that they have felt "depressed." What most mean by this is that they have felt sad. Sadness is a universal feeling, and everyone will experience some periods of intense sadness with grief. Not everyone, however, will have experienced a clinical depression. Sadness or depression is just one symptom of a depressive illness. One could think of the feeling of sadness as depression with a little "d" and the medical illness as depression with a capital "D." With any medical condition, doctors look for a combination of symptoms to make a diagnosis. They need to distinguish a particular symptom from a clinical syndrome which is a combination of symptoms that characterize a specific condition. One example would be the symptom of a cough. Coughing may be associated with many medical conditions including allergies, colds, pneumonia or cancer. To distinguish the cause, physicians must identify the other symptoms accompanying the cough. By learning that someone with a cough also has a high fever, has been coughing up sputum, and has a change in breathing detected by listening with a stethoscope, a doctor can differentiate pneumonia from a cold. The same is true for depression; by examining a person to identify other changes that accompany a depressed mood, those with a depressive illness can be distinguished from those experiencing sadness.

Why make a diagnosis of a depressive illness?

There is little debate about why a patient needs a diagnosis of pneumonia. As in all fields of medicine, the goal of making the diagnosis is to recommend treatment and to give a prognosis. The first step in the process is to identify a clinical syndrome which includes the symptoms the person is reporting. Once a diagnosis is made, specific information about the expected course of the illness and the treatment options can be discussed. This process is as necessary for depression as it is for pneumonia. People may avoid a diagnosis of depression because they fear being "labeled." Counselors may fear labeling students and teenagers may fear being labeled. Without the diagnosis, however, a depressive illness may go untreated with serious consequences.

How do we know that depression is an illness?

First, a person who has depression will have the same clinical syndrome as other individuals with the disorder; the majority of individuals suffering from depression will exhibit similar symptoms. While the details of the symptoms often vary among individuals, the same patterns can be traced across individuals, cultures and time periods. Second, there is strong evidence that there is a genetic component to depression. Depression and bipolar disorder (manic-depressive illness) both run in families. The stronger the family connection (for example sister rather than cousin) the greater the chance that another family member will have similar symptoms. Finally, there is some evidence that particular parts of the brain are linked to this illness. One example is that having a stroke in the left front of the brain rather than the right has been associated with higher rates of depression. The exact biological cause of this illness has not yet been identified, but the neurotransmitters serotonin and norepinephrine seem to have a very important role. As more is understood about the exact biological causes of this illness, the treatment can hopefully be refined.

Symptoms of Teenage Depression

- Depressed or irritable mood
- Decreased interest or pleasure in activities
- Change in appetite or weight
- Sleeping more or less than usual
- Feeling restless or slowed down
- Fatigue or loss of energy
- Feelings of guilt or worthlessness
- Decreased concentration
- Sense of hopelessness
- Substance abuse
- Recurrent thoughts of death or suicide

What are the symptoms of depression?

As outlined in the accompanying table, there are a number of symptoms of depression. They can be thought of as affecting

(Continued on Page 3)

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From the Editor's PC

Dear Colleague;

Welcome to our November issue of *The Prevention Researcher.* In this issue we tackle the often over looked problem of adolescent depression.

The issue begins with an introduction into the topic of adolescent depression by Karen L. Swartz, M.D., of Johns Hopkins Hospital. Dr. Swartz discusses how to recognize teenage depression, and includes a list of symptoms.

This is followed with an examination of depression in a multi-ethnic sample of youth by Judith Siegel, Ph.D. and colleagues at the UCLA School of Public Health. Dr. Siegel and her co-authors compare four ethnic-racial groups (African American, Asian American, Latino, and non-Hispanic White) to see if there is an impact of race-ethnicity on depressed mood, and whether gender differences in depressed mood are apparent within all race-ethnicity subgroups.

Dina M. Carbonell, Ph.D., Helen Z. Reinherz, Sc.D., and Rose M. Giaconia, Ph.D., all working on the Simmons Longitudinal Study, explore risk factors for depression and the factors that make some youth resilient against it. Drs. Heather E. Shaw and Eric Stice, both of the University of Texas at Austin, follow with a discussion of body image and eating disturbances and their relationship to depression in adolescent girls.

Next, Peter M. Lewinsohn, Ph.D., Paul Rohde, Ph.D., and John R. Seeley, M.S., all from Oregon Research Institute, examine results of their longitudinal adolescent depression project which has been on going since 1985. And finally, this issue is concluded with an article by Uma Rao, M.D., from the UCLA School of Medicine. Dr. Rao discusses the relationship between depression and substance use in adolescents.

I would like to take this opportunity to thank all of our authors for their work in this important field and for taking the time to share their findings with us.

Have a great winter,

Steven Ungerleider, Ph.D.
Psychologist/Editor
The Prevention Researcher

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one of three areas: mood, sense of vitality and attitude about one's self. The mood change may be one of sadness, but teenagers may also be irritable. A hallmark of depression is the inability to feel joy, which leads to a decreased interest in pleasurable activities. If spending time with friends or playing soccer is no longer fun, a teen's motivation to participate usually decreases. The change in vitality usually manifests as changes in appetite, weight, sleep, and energy level. Teenagers may also have periods of feeling very restless or agitated. During these times they may experiment with alcohol, drugs, self-injury, or eating disorder behaviors. If people in depressive episodes find that certain behaviors change how they feel, even if the effect is temporary, they often develop a regular habit of these destructive behaviors. Certainly teenagers without a mood disorder use drugs and alcohol or have eating disorders, but if both are present they can have a negative synergy. Teenagers' ability to think is affected by depression as well; they have a decrease in concentration and an inability to follow through with tasks. This often is first noticed by teachers who identify a change in performance and a drop in grades. The self-attitude change in depression manifests as a loss of confidence and a loss of self-esteem. This may lead to teenagers feeling that they are worthless and believing that they contribute very little. With more severe depression, teenagers may have strong guilt feelings or believe that they are burdens to their family. The most serious symptom of depression is suicidal thinking. Since depressed people can have their thoughts distorted by the illness, they may believe that their family would be better off without them. This potential for suicide makes depression a potentially fatal illness.

Every member of a family is impacted when someone has depression.

What is the difference between having a few symptoms and having a depressive illness?

In reviewing the list of depressive symptoms, people may identify several that seem "normal" or that they have experienced themselves. In a depressive illness there is a clustering of symptoms. To make the diagnosis of *major depression*, the term for an episode of depressive illness, five or more of the symptoms must be present for at least two weeks. At least one of the symptoms must be the change in mood (to depressed or irritable) or the loss of interest or pleasure in usual activities. To make the diagnosis of an illness, the symptoms need to have an impact on the teenager socially, academically, or emotionally. The real key is to look for a *change* in someone's mood and behavior. Some individuals are very good at hiding the symptoms, so not all depressive episodes are noticeable to others. Part of the evaluation process is talking with teenagers to identify changes they have experienced.

What should you do if you suspect that a teenager is depressed?

The key is helping that teen get into treatment. If teachers notice changes in academic performance or attitude, they may want to discuss these changes with the guidance counselor. If a counselor has heard about changes in multiple classes, or from a coach or activity advisor as well as a classroom teacher, there is even more reason for concern. The counselor should discuss the concerns with not only the student but also the parents so they can act on the recommendations. The first step is an evaluation by a trained health care professional. Both students and their parents need to be educated about the illness and the treatment options. As some people do not think of depression as a treatable medical condition, they may not feel that formal evaluation and treatment are necessary. A case must be made which stresses the risks of *not treating the illness.*

What is the treatment for depression?

The treatment of depression is typically a combination of antidepressant medications and psychotherapy. The antidepressant medications prescribed for adolescents are the same medications used to treat adults, but often they are started at lower doses which are increased more slowly. The most common group of antidepressants prescribed for teenagers is the Selective Serotonin Reuptake Inhibitors (SSRIs). These include medications such as Prozac, Zoloft, Paxil, Luvox, and Celexa. There are many other antidepressants which are possible options for the treatment of depression and the choice of an antidepressant should be tailored for each person. Individual psychotherapy gives teenagers an opportunity to discuss the stresses that may have triggered the illness as well as the challenges raised by having depression. In addition to individual talk therapy, families may benefit from sessions involving the entire family. Every member of a family is impacted when someone has depression; the family may need to discuss ways to handle the challenges that come with depression.

What are the risks of not seeking treatment?

The most serious risk is the potential for suicide. Suicide is the third leading cause of death in 15–24-year olds and the second leading cause of death among college students. In studies of completed suicide, approximately 90% of these individuals had a psychiatric illness identified during a post-mortem investigation. A particularly lethal combination is depression mixed with substance abuse and with access to a gun. The ongoing feelings of hopelessness and suicidal thoughts may be galvanized into action if someone is disinhibited by alcohol or other substances. Having access to lethal means is the final part of this deadly triad. The Surgeon General has identified teenage suicide as a national public health crisis. Treatment of the underlying psychiatric condition is critical for prevention.

Decreased school performance is a common "red flag" for depression.

While suicide is the most tragic result of untreated depression, those who never attempt suicide suffer significantly and are at risk for other serious consequences. Teenagers have many developmental tasks: to learn in school, to establish their independence, to begin dating and forming a variety of relationships, to think about long term plans, and to find a first job. If teenagers have major depression, they will not be able to accomplish these tasks. Since the primary "work" of an adolescent is school, decreased school performance is a common "red flag" for depression resulting from a lack of motivation, decreased concentration, and low energy. If a student's concentration is so affected that the student has trouble reading a novel, the student is likely to turn in the book report or paper late or not at all. Other consequences include a teenager's new or more intensive experimentation with alcohol or drugs. The impact of drugs and alcohol can be devastating and the treatments for depression may not be effective if someone continues to use drugs or alcohol. Feeling miserable all day every day has an impact on the choices teenagers make. It is difficult to "just say no" when one feels miserable. Treatment of depression must include control of alcohol and drug abuse or other destructive behaviors such as self-injury, restricting food or binge eating and purging.

If depression is an illness, is it fair to hold teenagers responsible for their behavior?

Major depression is a medical illness and it is not fair to blame someone for being ill. At the same time, it is important that people take responsibility for their health. Individuals with diabetes need not only to monitor their blood sugar and take insulin as prescribed but also to follow recommendations for diet changes and exercise. With depression, there is a need to be compliant with treatment, usually including medication, as well as to stop destructive behaviors.

Depression is a common medical condition which can be successfully treated. The greatest barrier to effective treatment is often not recognizing the symptoms. Anyone having a significant and ongoing change in his or her mood, sense of vitality and self-attitude should discuss the possibility of a depressive illness with a counselor or physician.

Dr. Karen L. Swartz, M.D., is an attending physician at Johns Hopkins Hospital and an Assistant Professor of Psychiatry in the Department of Psychiatry and Behavioral Sciences at the Johns Hopkins University School of Medicine. She is working with colleagues at Johns Hopkins and DRADA (the Depression and Related Affective Disorders Association) to develop a curriculum to teach students, faculty and parents about teenage depression.

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Adolescent Depressed Mood in a Multi-Ethnic Sample

By Judith M. Siegel, Ph.D., M.S.Hyg., Carol S. Aneshensel, Ph.D., Bonnie Taub, Ph.D., Dennis P. Cantwell, M.D., and Anne K. Driscoll, Dr.P.H.

Recent research on adolescent mental health supports that depressed mood is a commonly observed phenomenon in adolescence. There is consensus among clinical and community studies that adolescent girls report and exhibit more symptoms of depression than adolescent boys. These gender differences, largely absent or possibly reversed in childhood, persist into adulthood, with the prevalence of depression in community studies of adults being about twice as high for women as men.

The co-occurrence of pubertal change and the excess of depressive symptoms among girls raises the possibility of biologic mediation. Hormonal functioning and pubertal status do have an impact upon depressive symptoms, but they are less influential than the large number of life events that are experienced during early adolescence. Depression might be particularly pronounced among girls who do not like the changes associated with puberty or who are changing early, relative to their peers. Among boys, in contrast, many of these attributes (e.g., height, strength) are associated with higher status.

Social class and race-ethnicity have also been identified as correlates of adolescent depressive symptoms, although there is a tendency to confound race with social class, and possibly with family structure, as well. African American adolescents are four times more likely, and Hispanics are three times more likely to be living below the poverty line than White adolescents. Likewise, about half of all single-parent families are below the poverty line, and this family type is about twice as common among African American as White children or adolescents. Being of lower social class is associated with higher emotional distress among adolescents and this effect is partly a function of the greater number of undesirable life events that economically disadvantaged youth experience.

Typically a small proportion of adolescents who report depressed mood in community studies meet the criteria for a clinical disorder. On the other hand, depressed mood is a defining criterion for depressive disorders and syndromes during adolescence, with over 90% of adolescents with major depressive disorder reporting depressed mood. Depressed mood is the most potent factor for discriminating between clinically referred and non-referred adolescents, and symptoms of depression co-occur with other psychological disorders, especially anxiety, substance abuse, suicide attempts, and antisocial behavior.

> ***Teenage girls reported more symptoms of depressed mood than teenage boys.***

We compared four ethnic-racial groups (African American, Asian American, Latino, non-Hispanic White) and will address three concerns: whether there is an impact of race-ethnicity on depressed mood, independent of social class; whether gender differences in depressed mood are apparent within all race-ethnicity subgroups; and whether pubertal development influences depressed mood in a similar manner within gender and race-ethnicity subgroups.

Method

Participants were randomly selected from households in Los Angeles County. In those households with multiple adolescents, one was selected randomly using the next-birthday method. From the 1,417 eligible households, interviews were completed with 877 (62%) adolescents. At least one parent was interviewed for the majority of adolescents (90%).

Recruitment and interviewing began in October 1992 and ended in April 1994. Interviews were conducted in-person in either English or Spanish with the interviewer matching the racial-ethnic composition of the neighborhood.

> ***For Latino teens in particular, higher level of depressed mood was associated with early or late pubertal development, relative to being on time.***

Race-ethnicity was determined by asking adolescents with which of the racial-ethnic groups they most closely identified. Pubertal development was assessed by Petersen and colleagues' self-report Pubertal Development Scale. Development is rated as "no development" (scored as 1) to "development was complete" (scored as 4). The level of development score is the average of five items. Depressed mood was measured by Kovacs and Beck's Children's Depression Inventory (CDI), the most commonly used self-report measure of depression in children.

The 877 adolescents were between the ages of 12 and 17 years (average=14.5 years). Males and females were about equally represented. Latinos were the largest racial-ethnic subgroup (49%), followed by Whites (26%). A majority of the teens in this sample resided with two parents—either both natural or adoptive parents (58%), or a parent and step-parent (13%). The remainder lived with one parent (26%) or with other relatives or guardians (3%). The sample was diverse in its socio-economic characteristics. Parental education (based on the parent's own reports) ranged from less than elementary school to post-graduate. The median annual household income (based on the mother's report) was $28,750, which translates into a per capita income of $8,452. About one quarter (24%) of the households in our sample lived below the federal poverty standard.

Results

The sample means are weighted to approximate the 1990 Census racial-ethnic distribution and to adjust for households with multiple eligible adolescents. All differences reported here are statistically significant. Teenage girls reported more symptoms of depressed mood than teenage boys and Latinos had higher CDI scores than Whites, African Americans or Asian Americans. This difference remained whether English or Spanish language interviews for Latino respondents were considered. Adolescents in the early stages of pubertal development reported fewer symptoms of depressed mood than those in the later stages. Teens whose mother or father had less than a high school education had higher CDI scores than the children of parents who had completed twelve or more years of schooling. Poorer teens, particularly those below the poverty line, had higher CDI scores than those above poverty level. Neither age nor family structure were related to reports of depressed mood. See Table I.

To determine if the influence of race-ethnicity on depressive symptoms was independent of social class, the race-ethnicity effect was tested controlling for income. Latinos had higher CDI scores than Whites, African Americans or Asian Americans, even when taking income or parents' education into account. The proportion of teens in poverty was about the same for Latinos (35%) and African Americans (31%), but substantially lower for Asian Americans (12%) and Whites (7%).

TABLE I

Children's Depression Inventory Scores (N=877).

Characteristic	Percent	Mean CDI*
Gender		
Male	53.5	9.23**
Female	46.5	10.88
Race-Ethnicity		
Latino	48.6	11.35**
White	25.9	7.90
African American	11.4	9.68
Asian American	10.6	9.57
Other	3.5	9.02
Pubertal Development		
Early	16.6	9.16**
Middle	44.6	9.34
Developed	38.8	11.12
Poverty		
Below the cutpoint	26.9	11.79**
At the cutpoint to twice poverty level	26.8	9.93
Above twice poverty level	46.3	8.99
Father's Education		
12 years or less	58.6	10.92**
13 years or more	41.4	8.70
Mother's Education		
12 years or less	65.7	10.86**
13 years or more	34.3	8.98

*CDI scores range from 0 to 63, with higher numbers indicating higher levels of depressive symptoms.

**$p \leq .001$.

Age was unrelated to depressed mood for boys, but older teenage girls and girls who were more developed had significantly higher scores than younger or less developed girls. Gender differences in depressed mood were evident for both the oldest teens (16 to 17 years) and the middle group (14 to 15), but not among the early adolescents (12 to 13). Likewise, within the category of the most advanced pubertal development, girls reported more symptoms of depressed mood than boys. The depression scores for the cross-classification of gender and pubertal status are presented in Table II (on page 6).

Regarding pubertal timing, boys' perception of being late relative to one's peers was associated with higher scores on depressed mood than being early or on time in pubertal development. Girls who rated themselves as on time were less depressed than either early or very late developers. Among Latinos, early and late developers scored higher on the CDI than those who rated themselves as on time, whereas there was no impact of timing on depressed mood among the other racial-ethnic groups.

TABLE II

Children's Depression Inventory Scores as a Function of Gender and Pubertal Development (weighted).

Characteristic	Percent	Mean CDI*
Males		
Early	12.7	9.65
Middle	27.9	8.86
Developed	12.9	9.63
Females		
Early	3.9	7.59**
Middle	16.8	10.14
Developed	25.8	11.85

*CDI scores range from 0 to 63, with higher numbers indicating higher levels of depressive symptoms.

**$p \leq .001$.

Discussion

Female adolescents in our sample endorsed substantially more depressive symptoms than males. White males had the lowest CDI score of all of the racial-ethnic and gender subgroups (shown in Table III). The smaller gender spread among Latinos was a function of Latino males reporting a fairly high level of symptomatology, rather than Latino females reporting few symptoms.

One of the normative, potentially stress-engendering changes during adolescence is pubertal development. For Latino teens in particular, higher level of depressed mood was associated with early or late pubertal development, relative to being on time. At least for Latinos, the notion of non-conformity being especially distressing is consistent with findings that self-esteem declines more steeply during early adolescence for Latino than for White or African American girls.

TABLE III

Children's Depression Inventory Scores as a Function of Gender and Racial-Ethnic Group (weighted).

Characteristic**	Percent	Mean CDI*
Males		
Latino	26.0	11.00
White	14.2	6.29
African American	6.5	8.92
Asian American	5.9	9.41
Females		
Latino	24.4	11.72
White	12.7	9.69
African American	5.2	10.39
Asian American	5.1	9.98

*CDI scores range from 0 to 63, with higher numbers indicating higher levels of depressive symptoms.

**Respondents whose racial-ethnic group was "other" (n=30) are excluded.

Our supposition is that the relationship between advancing pubertal status and depression is not direct. Evidence converges in suggesting that interpersonal stressors, low self-esteem, and negative body image, all of which increase with age and advancing pubertal status among girls, are mediating the observed association. In line with prior research, depressive symptoms were particularly pronounced among girls with early pubertal development and among boys with late development, but only when using measures of perceived rather than actual pubertal timing. We found that girls also responded negatively to late maturation, corroborating the suggestion that being on time is especially valued by girls. Thus, while neither age nor pubertal status by itself had an influence on depressive symptoms among boys, the timing of pubertal development did covary with depression.

Latino teenagers reported more depressive symptoms than teens of other racial-ethnic backgrounds. Comparable psychometric characteristics for the CDI were demonstrated across groups, suggesting that the measure is reliable within sub-groups. An untested possibility is that Latino adolescents felt more comfortable acknowledging or reporting distress than did teens from other racial-ethnic groups. Most likely, the higher rates of depression among Latinos were not a methodological artifact, but reflect instead their greater exposure to noxious social conditions, especially on going or chronic stressors, which in turn contribute to distress.

Paramount among these chronic stressors is inadequate financial resources. There were clear social class effects on depression, showing that as income diminished, the average level of depression increased. Similar associations to income were found for mother's and father's education. Several studies have shown that the greater vulnerability of adolescents from low-income backgrounds to depression is in part a function of experiencing more stressful life events.

The independent effect of race-ethnicity on depression, when controlling for income and parents' education, suggests that factors in addition to economic resources are contributing to the observed symptom patterns. Further research is needed to identify the domains of stressors, as well as the resources for ameliorating stress, that may vary as a function of racial-ethnic group. Such research should attempt to address the political, economic, and social context in which non-White adolescents live.

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Risk for Depression and Resilience in Late Adolescence

By Dina M. Carbonell, Ph.D., Helen Z. Reinherz, Sc.D., and Rose M. Giaconia, Ph.D.

Depression among children and adolescents has been widely studied because of the toll it takes on effective functioning and on the emotional lives of young people. Childhood depression is also associated with a variety of problems in adulthood that compromise functioning and well-being. These consequences make it compelling to identify both risk factors contributing to early depression and factors that serve a preventive or protective role, making it possible for those at risk to enter adulthood with positive psychosocial functioning.

This study was part of a larger longitudinal study that has followed a cohort of young people from 1977, when they were in kindergarten, to young adulthood. It looked at adolescents at-risk for major depression and compared those who became depressed, those who developed other psychiatric problems, and those who did not develop a psychiatric disorder, to see what made a difference in their lives. It also examined the ways in which the at-risk adolescents who could be considered "resilient" (without a disorder and functioning particularly well) differed from their non-disordered peers who were functioning adequately but not extraordinarily well.

Background

Risk factors for depression and other emotional difficulties can be categorized in several ways, including negative life events, individual characteristics (such as anxiety), or circumstances in one's family or outside environment. The presence of a risk factor is not a predictor of a difficulty in any absolute way; rather, its presence makes it more likely that a person will develop a particular problem.

Protective factors, also called protective mechanisms, are factors that make it more likely that someone will be "resilient," or do well, despite the presence of risk factors. A child who is at risk for emotional difficulties because of non-supportive parents, for example, may do well if there is an attentive, caring relative available. (In this example, the protective factor would appear to compensate for the risk factor or attenuate the effects of a negative influence.) Prevention efforts and clinical interventions can promote resilience through incorporating protective factors that have been identified as relevant to particular areas of risk.

> ***The depressed group reported greater difficulties of an internalizing nature, including social withdrawal, apathy, and feelings of worthlessness.***

Description of Study

The resilience study is part of a longitudinal study that has followed a community population that consisted primarily of white, working-class and lower-middle-class families living in a relatively stable community near a large metropolitan area in the Northeastern United States. The study gathered comprehensive data at ages 5, 9, 15, and 18, using structured interviews with more than 400 respondents, their parents, and their teachers. It included measures of academic, psychological, family, and social functioning.

Early risk factors for depression in late adolescence (age 18) found in this sample included a negative perception of one's role in the family and unpopularity at the age of nine, as well as anxiety at the age of fifteen, reported by either the adolescent or the parent. In addition, risk factors for females included family composition factors (position later in the birth order, having older parents, and having at least three siblings), anxiety at age nine, health problems arising between the ages of ten and fifteen, the death of a parent by the age of fifteen, and pregnancy by mid-adolescence. For the males, additional risk factors included health problems at birth, a serious illness by the age of five, dependency at the age of five, family conflict between the ages of ten and fifteen, and parental remarriage by the age of fifteen.

Differences Among the Three Groups of At-Risk Adolescents

We initially grouped the 108 adolescents who had three or more risk factors for depression by diagnostic category:

(1) Depression,
(2) Other Diagnosis (anxiety and substance disorders), and
(3) No Diagnosis.

In comparing the groups, differences between them emerged in the areas of behavioral problems, academic functioning, and social and emotional adjustment.

Differences in Behavioral Difficulties. Distinct differences were noted in the overall behavioral functioning in the three diagnostic groups. As anticipated, the Depressed group reported greater difficulties of an internalizing nature, including social withdrawal, apathy, and feelings of worthlessness. In addition, they reported a greater number of externalizing behaviors (such as aggression, disruptive acts, or impulsivity) than their peers with no diagnosis. Child clinicians have noted that adolescent depression often manifests as aggressivity or irritability, a phenomenon that would be consistent with this finding.

Differences in Academic Functioning. The only difference in grade point average was that the Other Diagnosis group had a significantly lower GPA than either of the other two groups. Interestingly, the Depressed group's GPA did not differ from that of the No Diagnosis group, suggesting that depression at this age is not associated with difficulties in school performance. No differences were found in the likelihood of dropping out of school, but that could be a factor of the low overall dropout rate for the total group of participants in this study.

Differences in Social and Emotional Adjustment. Members of the Depressed group were more likely to have low self-esteem than their peers with no diagnosis. They were also more likely to report interpersonal problems, anxiety, and unpopularity. They had a more negative view of themselves and the worlds they lived in than their peers, which is not surprising in light of the tendency among depressed people to have negative perceptions and thoughts.

Differences Between Resilient Youth and Others

Our next comparison focused on the adolescents with no emotional disorders. Of 108 youth at risk for depression, 42 had no diagnosis. It could be said that they were all doing well, at least relative to their at-risk peers who had become depressed or had developed other disorders. Indeed, 14 of these 42 were doing exceptionally well. They had positive self-esteem and were functioning well in all areas relevant for their developmental stage. These were the *resilient adolescents.*

Resilience is the phenomenon of unexpected or unlikely positive outcomes among individuals at risk for psychosocial problems. It has been defined as the capacity to be unaffected by, to recover from, or even to gain strength or to grow from difficult life experiences or adversity. We defined resilience as positive functioning and well-being in the presence of risk. Those who were resilient, in addition to having no psychiatric disorder, had positive self-esteem, adequate academic performance, fewer behavioral problems, good psychosocial functioning, and positive interpersonal relationships.

To identify factors that contribute to exceptionally positive outcomes among adolescents at risk, we compared the resilient youth to the remainder of the group without a mental health diagnosis. Differences emerged between the two subgroups in two critical areas that can help inform clinical practice and prevention program development (see Table A).

TABLE A

Factors Associated with Resilience in Late Adolescents at Risk for Depression

Family Factors

- A sense of togetherness
- Help among family members
- Ability to resolve conflict
- Positive communication
- Clear leadership in the family
- Sharing of emotions
- Parental satisfaction with school achievements
- Positive sibling relationships
- Sibling support

Social Support

- Satisfaction with financial assistance available
- Satisfaction with level of positive feedback
- Lower perceived need for additional advice

Characteristics of Resilient Adolescents' Family Environment. There were a number of environmental characteristics present in the families of the resilient adolescents. They were more likely than their peers to describe their families as cohesive (e.g., spending time together or feeling close). They were also more likely to report positive family functioning in such areas as making decisions together or managing conflict in constructive ways. Being part of a cohesive family that communicates and functions well as a unit appears to enhance the capacity for resilience among late adolescents at risk for depression.

The perception of parental support throughout their lives seems to be important for resilient teenagers. The parents of the resilient adolescents reported a higher level of satisfaction with their children's achievement in school by third grade than the parents of the comparison group members. They also reported having the expectation that their child would do well. The positive attitude of parents in this area seems to be associated with positive functioning in later years.

An examination of family relationships over the teenage years showed that siblings, as well as parents, can be important for adolescent well-being. At age fifteen, the resilient teenagers had reported a significantly greater degree of harmony with their siblings than the comparison group. They were also more likely to mention siblings as major sources of support.

Social Support Factors Associated with Resilience. The resilient adolescents did not differ from their peers in their reports of support network size or composition when asked to list the people to whom they turned for various types of support in their lives. However, they reported a higher level of satisfaction with some of the support that was available to them, particularly financial help and positive feedback. They also reported a lower level of unmet need for advice than the other group. This could indicate that the resilient adolescents had less of a need to rely on others, perceived the support they received as more effective or useful, or felt more comfortable with autonomous decision-making.

Discussion

The finding that family cohesion and support continue to play a central role in the well-being and functioning of young people emerging from adolescence is important. There is a commonly held belief that in late adolescence youth function with relative autonomy. The ongoing importance of their family in their lives is demonstrated by the association of family factors with resilience in late adolescence. Feeling close to one's family may actually contribute to competence in autonomous functioning. This is a similar phenomenon to that of secure attachment in early childhood.

The differences in perception of social support may indicate differences in the quality of actual support received or a more positive interpretation on the part of the resilient adolescents. Their lower need for support may reflect self-reliance, more autonomy, or a higher level of satisfaction with the support that is available to them. The difference in the positive feedback category may also reflect a greater ability among the resilient group members to internalize positive feedback, to trust its authenticity, or to use it effectively to enhance well-being.

The findings of this study reveal a strong relationship between resilience among adolescents at risk for depression and the availability of family and social support. The continuing importance of family in the lives of young people who are on the brink of adulthood may be surprising in a culture that promotes and values autonomy and independence. It suggests that even if a significant degree of autonomy is achieved by the age of eighteen, the at-risk adolescent continues to benefit greatly from family support.

The ability to meet life's demands successfully is developed largely through children's experiences of challenging events that do not become overwhelming. Family cohesion and social support may provide protection, directly or indirectly, to keep risk factors from overwhelming the adolescent, keeping those factors in the realm of challenging experiences that foster growth rather than negative outcomes. Belonging in a family offering a cohesive, well-functioning environment where members communicate openly with one another fosters important resources within the developing child. It also protects the child from the effects of a risk factor; anxiety, for example, may well elicit protective responses from caring family members.

> ***The findings of this study reveal a strong relationship between resilience among adolescents at risk for depression and the availability of family and social support.***

Individual factors associated with resilience, such as positive self-esteem, develop in a social context. A supportive environment creates the culture necessary for the development of resilience. The salience of family factors and social support is consistent with professional knowledge in the area of adolescent development. Enhancing family environment and social support clearly is important in decreasing the likelihood of depression in late adolescence when risk factors cannot be eliminated. Further research with other populations can continue to inform prevention efforts and treatment programs for young people.

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UPCOMING TOPICS

Mentoring. Big Brothers Big Sisters has been involved in mentoring for 90 years, and other programs have followed suit, yet mentoring programs have only recently been evaluated. Volume 9(1) of *The Prevention Researcher* will take an in-depth look at adult-to-adolescent mentoring.

Grief and Bereavement. How does the loss of a parent, sibling, friend, or teacher affect adolescents? Are there differences between sudden, traumatic deaths, and deaths caused from long illnesses? How should professionals working in schools and community organizations respond? Volume 9(2) of *The Prevention Researcher* will look at these questions and more.

Other future issues include: Adolescent Drunk and Drugged Driving, Teen Parents, and Resiliency.

WEB RESOURCES

Depression and Related Affective Disorders Association
www.med.jhu.edu/drada/

DRADA works in cooperation with the Department of Psychiatry at the Johns Hopkins University School of Medicine. This web site includes information on depression in general as well as specific information on adolescent depression, including the pamphlet "I wish I was never born. I really hate myself." This pamphlet is designed for youth who are depressed or who have a depressed friend (single print copies are available for free by calling 410-987-7447). Another nice feature of this site is the "common questions from teens" page.

Mental Health: A Report of the Surgeon General – Depression and Suicide in Children and Adolescents
www.surgeongeneral.gov/library/mentalhealth/chapter3/sec5.html

Published in 1999, "depression and suicide in children and adolescents" is one small part of this very large report by the Surgeon General. This section covers definitions of various types of depression, prevalence rates, causes, the connection between depression and suicide, and treatment.

Mental Health Net: Depression
www.mentalhelp.net/guide/depress.htm

Mental Health Net provides a list of links to other resources on the Internet. It contains many nice features not found on other lists of links. First, the links are fully annotated so you know what you will encounter when you get there. Second, the authors of the web sites are noted, so you have some idea of their credentials. And finally, the sites are rated both by Mental Health Net and by other readers.

National Institute of Mental Health – Depression in Children and Adolescents: A Fact Sheet for Physicians
www.nimh.nih.gov/publicat/depchildresfact.cfm

Written in August of 2000, this extensive fact sheet provides information on the scope of the problem of depression among children and adolescents, summarizes some of the latest scientific findings (including clinical characteristics, risk factors, and treatment), and provides resources for further information.

Body Image and Eating Disturbances as Risk Factors for Depression

By Heather E. Shaw, Ph.D. and Eric Stice, Ph.D.

Approximately 20% of adolescents meet lifetime criteria for major depression, making it one of the most prevalent psychiatric disorders. Adolescent depression is related to suicide attempts and high rates of comorbid (co-occurring) anxiety disorders, disruptive behavior disorders, and substance abuse. Additionally, it predicts future adjustment problems including academic failure, unemployment, substance abuse, delinquency, and marital and legal problems. By late adolescence, twice as many girls are depressed as boys, suggesting that different developmental risk factors are operating. These gender-related pathways to depression remain largely unexplained. Accordingly, this paper will review evidence for a gender-based model of depression which attempts to delineate why adolescent girls appear to be at higher risk for this disorder.

Gender-Additive Model of Depression

The gender-additive model which suggests that girls face an additional set of risk factors above and beyond those they share with boys, may provide a heuristically useful framework for understanding why adolescent girls experience higher rates of depression. Theoretically, body image and eating-related concerns are triggered as puberty moves girls away from the current thin ideal, and these concerns likely contribute to their higher depression rates. Because puberty moves boys closer to their culturally prescribed ideal, these additional risk factors for depression are absent. For instance, research suggests that girls generally dislike the physical changes associated with puberty (e.g., the increase in adipose tissue), while boys usually like the physical changes they experience (e.g., the increase in muscle mass).

Specifically, the gender-additive model postulates that elevated body mass, perceived pressure to be thin, thin-ideal internalization, body dissatisfaction, and dieting are thought to work together in a mediational fashion to promote mood problems for adolescent girls. Elevated body mass is thought to lead to body dissatisfaction because overweight is not currently socially desirable. Heightened body mass may also result in amplified perceived pressure to be thin from family, peers, and the media. Girls who experience early menarche might be at greater risk, as they are most physically deviant from their pre-pubescent peers. Perceived pressure to be thin is then thought to foster internalization of the thin-ideal body image for women. These socialization agents can reinforce this ideal through comments or actions that serve to support and perpetuate the thin-ideal (e.g., criticism regarding weight, encouragement to diet). Perceived pressure to be thin from these sources can also directly lead to body dissatisfaction, as repeated messages that one is unattractive would be expected to produce discontent with physical appearance. Internalization of the thin-ideal putatively contributes to body dissatisfaction as this ideal is virtually impossible to achieve.

Body dissatisfaction in turn might promote depression, as appearance is one of the central evaluative dimensions for females in Western cultures. Body dissatisfaction might be particularly likely to produce depression in our society because it is commonly accepted that more exercise and a lower fat diet can lead to achieving an ultra-thin body (i.e., that it is under volitional control). Following from the accepted belief that caloric restriction is an effective means of weight control, body dissatisfaction is also thought to result in elevated dieting behaviors, which can serve to foster depression. This is because emotional distress may result from the failures associated with dietary efforts or could directly result from the adverse effects of caloric deprivation on mood. Bulimic symptoms, which theoretically result from body dissatisfaction and dieting, may contribute to the increases in depressive symptoms in adolescent girls because of the shame and guilt that can result from engaging in bulimic behaviors. Bulimic pathology might also contribute to depression because of the distress resulting from repeatedly losing control over eating.

In sum, elevated body mass, pressure to be thin, thin-ideal internalization, body dissatisfaction, dieting, and bulimic pathology are hypothesized to predict increases in depressive symptoms among adolescent girls. Furthermore, these risk factors are thought to operate above and beyond the gender non-specific risk factors for mood disturbances to help explain the elevated rates of depression for adolescent girls.

> ***Elevated body mass, perceived pressure to be thin, thin-ideal internalization, body dissatisfaction, and dieting are thought to work together to promote mood problems for adolescent girls.***

To date, much of the research in this area has been cross-sectional, and thus has limited inferential value. Further, it has not examined the relation of a broad spectrum of body image and eating related factors, and has focused on depressive symptoms rather than diagnostic levels of major depression. Thus, a central goal of our research team was to improve on past research by using prospective studies to test our etiologic account.

The first in a series of studies examining these issues was a 4-year school-based longitudinal study (N=1,124). Findings from this preliminary study are consistent with a gender-additive model of depression. Increased body dissatisfaction, dietary restraint, and bulimic symptoms at study entry predicted the onset of subsequent depression among initially non-depressed adolescent girls in bivariate analyses controlling for initial depressive symptoms. Although the unique effect for body dissatisfaction was not significant in the multivariate model, this set of risk factors fairly accurately predicted which girls developed major depression. Interestingly, body mass did not emerge as a risk factor for onset of depression, suggesting that attitudinal disturbances involving the thin-ideal are more important than actual body dimensions in the prediction of depression onset.

A follow-up study using data from a longitudinal community study (N=231) generally replicated these findings. Specifically, this investigation found that initial pressure to be thin, thin-ideal internalization, body dissatisfaction, dieting, and bulimic symptoms, but not body mass, predicted subsequent increases in depressive symptoms, as did increases in these risk factors over the study. These effects remained significant when other established gender-nonspecific risk factors for depression (social support and emotionality) were statistically controlled. These results also provide support for the assertion that body image and eating disturbances, operating above and beyond gender-nonspecific risk factors, contribute to the elevated depression in adolescent girls.

Promising Prevention Program

Psychoeducational primary prevention programs (didactic presentations by health professionals) represent the most common type of eating disorders prevention intervention, however, they have met with little success. Therefore, an innovative dissonance targeted prevention intervention was developed, which has been empirically supported in two published studies. This prevention program challenges women with body image concerns to voluntarily argue against the media-portrayed thin-ideal.

A preliminary test of this program looked at female undergraduates (N=30) with elevated body concerns, assigning them to a three-session intervention, where they argued against the thin-ideal, or a delayed-intervention control group. The intervention resulted in a subsequent decrease in thin-ideal internalization, body dissatisfaction, dieting, negative affect, and bulimic symptomatology, with most changes remaining at one-month follow-up. These preliminary results suggest that this dissonance-based targeted prevention intervention reduces bulimic pathology and known risk factors for eating disturbances, and provide experimental support for the claim that thin-ideal internalization contributes to body dissatisfaction, dieting, negative affect, and bulimic symptoms.

A second study tested this dissonance-based intervention experimentally with a larger sample (N=87) of women with body image concerns. These women were randomized to this intervention, which involves verbal, written, and behavioral exercises requiring them to critique the thin-ideal, or to a healthy weight management control group. Participants completed a baseline, termination, and 4-week follow-up survey. Participants in the dissonance intervention reported decreased thin-ideal internalization, body dissatisfaction, dieting, negative affect, and bulimic symptoms at termination and 4-week follow-up. Unexpectedly, participants in the healthy weight management control group also reported some benefits. Taken in conjunction with past findings, these results suggest that the dissonance intervention, and to a lesser extent the healthy weight management intervention, may reduce bulimic pathology and risk factors for eating disturbances.

There is also support for the importance of targeting body dissatisfaction. Specifically, a cognitive behavioral intervention that decreased body dissatisfaction resulted in subsequent reductions in negative affect and depression. These reductions lasted through the 6-month follow-up.

Another possible explanation why these interventions have been successful is that they represent a "covert" type of intervention, wherein high risk females partake in a program that is portrayed as a "body acceptance" rather than "depression" or "eating disorders" prevention program *per se*. An additional benefit of such a "covert prevention" approach is that it does not require insight regarding eating disturbances on the part of the participant to entice them into enrolling in the programs. This ultra-high risk group would be missed if insight is required for enrollment.

Directions for Future Research

The findings from these prospective studies suggest that body-image and eating-related risk factors that emerge after puberty, operating above and beyond gender non-specific risk-factors, may contribute to the elevated rates of depression in adolescent females. Further, despite methodological and measurement differences, the second study replicated findings from the preliminary study, adding increased confidence in the robustness of the effects. Nonetheless, because the studies only examined the risk factors for increased depression among adolescent girls, it only represents a partial test of the gender-additive model. Future research will need to test whether weight-related risk factors escalate in early adolescence for girls, but not boys, and whether the different levels of these risk factors explain gender differences in depression. Research should also assess how the risk factors in the gender-additive model work in conjunction with other factors that have been advanced to explain the gender differences in depression, such as intensified gender socialization and coping style. Future studies might also include other general risk factors for depression that apply to both boys and girls (e.g., deficits in social support and negative life events) to provide a more precise test of the hypothesis that body-image and eating-disturbance-related risk factors operate above and beyond these more general risk factors. Finally, studies should also start at an earlier age so that the timing of the increases in risk factors can be clearly documented and linked to the emergence of gender differences in depression.

> ***Programs that effectively reduce body dissatisfaction, dieting, and bulimic symptoms might be useful in decreasing the incidence of major depression among female adolescents.***

Prevention Implications

This article identified several malleable risk factors that could be targeted in prevention efforts. Data suggest that programs that effectively reduce body dissatisfaction, dieting, and bulimic symptoms might be useful in decreasing the incidence of major depression among female adolescents. These risk factors could be used to identify high risk groups for targeted prevention efforts. Further, interventions that target all of these risk factors might be extremely potent for preventing depression among adolescent girls. Finally, because these studies provide evidence that bulimic pathology and major depression share some common risk factors, prevention programs could combine efforts and target these overlapping groups. ⁓

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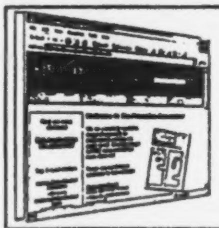

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Depression in Older Adolescents

By Peter M. Lewinsohn, Ph.D., Paul Rohde, Ph.D., and John R. Seeley, M.S.

In the past 25 years, substantial progress has been made toward furthering our understanding of depression among adults. Much less is known, however, regarding depression in children and adolescents. Beginning in the 1970s, a number of researchers began to focus on affective disorders in children and adolescents, concluding that depressive disorders clearly occur during this age. We have been engaged in extensive research on the epidemiology and treatment of adolescent depression since the mid-1980s. The goal of this article is to summarize our current understanding of depression in adolescents based on this body of research.

Our Data

Since 1985, we have been conducting a large, prospective, epidemiologic study entitled the Oregon Adolescent Depression Project (OADP). The OADP consists of a representative sample of 1,709 high school students who completed a diagnostic interview and a wide array of psycho-social measures when they were 14 to 18 years of age. Approximately one year later, 88% of the participants returned for a second diagnostic interview and questionnaire assessment. There were no differences between those who continued and those who dropped out on important clinical and demographic dimensions (e.g., percent living with both biological parents, or depression and other psychopathology). We completed a third diagnostic assessment with the OADP participants near the time of their 24th birthday, and we are currently in the process of conducting a fourth diagnostic assessment at age 30. This article uses the data from the first two assessment periods. We hope that the results will provide important information regarding the impact of psychopathology during the transition from adolescence to adulthood.

Average age of the OADP sample at the initial interview was 16.6 years. Slightly over half of the participants (53%) were female; 91% were White; 12% had repeated a grade in school; and 53% were living with both biological parents at the time. Most participants resided in households in which one or both parents worked as a minor professional or professional (74% combined).

Phenomenology

Frequency of Symptoms. To examine the manifestation of an episode of Major Depressive Disorder (MDD) in adolescence, we calculated the relative frequency of DSM-III-R depressive symptoms for adolescents in an depressive episode. Results are shown in Table 1. As can be seen, in addition to depressed mood, the most frequent symptoms are thinking difficulties, sleep disturbances, and weight/appetite disturbances. The least frequent symptom is thoughts of death/suicide, which, nonetheless, was reported by over half of the depressed cases.

Of the adolescents who met criteria for major depressive disorder, the mean number of symptoms was 6.9. Of the two core symptoms of MDD, depressed mood is more prevalent than anhedonia in depressed adolescents (97.7% vs. 77.3%); anhedonia rarely exists in the absence of depressed mood (2.3% of MDD cases), and in 75% of MDD cases both core symptoms are present.

TABLE 1

Major Depressive Symptoms Among Depressed and Non-Depressed Adolescents

	Depressed	Non-Depressed
Depressed Mood	97.7%	10.1%
Anhedonia	77.3%	3.7%
Weight/Appetite Disturbance	79.5%	8.6%
Sleep Disturbance	88.6	11.9%
Motor Disturbance	68.2%	4.6%
Loss of Energy	68.2%	8.6%
Worthless/Guilt	70.5%	5.7%
Thinking Difficulties	81.8%	9.7%
Thoughts of Death/Suicide	54.5%	1.6%

Adapted from R.E. Roberts, P.M. Lewinsohn, and J.R. Seeley. (1995). Symptoms of DSM-III-R major depression in adolescence: Evidence from an epidemiological survey. *Journal of the American Academy of Child and Adolescent Psychiatry,* 34, 1608-1617.

Community vs. Clinic Cases. We also examined whether community-based MDD cases are phenomenologically similar to MDD cases in treatment settings. Data from the OADP study were compared with results from six published studies of adolescent patients (inpatients and outpatients) who had received the diagnosis of MDD.

We found that diagnosed cases of MDD from our community survey are very similar to clinical cases in treatment settings (see Table 2). With two exceptions, prevalence rates of symptoms in the OADP sample fall within the range of the six patient samples. The exceptions are weight/appetite disturbance and sleep difficulties, which were more often reported by the OADP participants. Another trend was for community subjects to report fewer thoughts of death and/ or suicidal tendencies than their clinical counterparts, albeit the 55% prevalence rate is well within the range of the clinical samples.

GLOSSARY

Anhedonia: the inability to enjoy what is usually pleasurable.

Depressed Mood: feelings of sadness; feels sad or empty; appears tearful. For clinical significance, depressed mood most of the day, nearly everyday for a period of one to two weeks.

Dysthymic Disorder: long lasting, persistent, mild depression. Symptoms are similar to those of major depression but are less severe.

Major Depressive Disorder (MDD): five or more of the following symptoms over a two week period: depressed mood, diminished interest or pleasure in most activities, weight/ appetite disturbance, insomnia or hypersomnia, observable motor disturbance, fatigue, feeling of worthlessness/guilt, indecisiveness or inability to concentrate, and recurrent thoughts of death.

TABLE 2

Prevalence of DSM-II-R Criteria for Major Depressive Disorder in Adolescent Community "Cases" and Treated Samples

	OADP Survey	**Six Treatment Samples, Mean (range)**
Depressed Mood	98%	94% (88%-100%)
Sleep Disturbance	89%	64% (57%-74%)
Thinking Difficulty	82%	81% (70%-92%)
Weight/Appetite Disturbance	80%	51% (36%-68%)
Anhedonia	77%	82% (70%-100%)
Worthlessness/Guilt	71%	65% (56%-92%)
Motor Disturbance	68%	44% (18%-70%)
Loss of Energy	68%	65% (30%-92%)
Thoughts of Death/Suicide	55%	73% (49%-92%)

Adapted from R.E. Roberts, P.M. Lewinsohn, and J.R. Seeley. (1995). Symptoms of DSM-III-R major depression in adolescence: Evidence from an epidemiological survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 1608-1617.

Age Differences. Given that the community cases of MDD appeared comparable to clinic cases, we examined whether the phenomenology of MDD changes during childhood and adolescence. To accomplish this, symptom prevalence values were compared in MDD episodes that occurred before age 14 (n = 100) with episodes that occurred after age 14 (n = 292). None of the differences in symptom prevalence for the two age groups were significant. A more important test of the age question would be to compare the symptom prevalence rates for MDD in adult samples. The pattern of symptoms in our depressed adolescents is generally similar to results from depressed adults identified in the Epidemiologic Catchment Area study (the most extensive study of the prevalence of the most important mental disorders in the U.S. at that time). Depressed adolescents were more likely to report worthlessness/ guilt than depressed adults and were less likely to report weight/ appetite changes and thoughts of death or suicide. Overall, these findings suggest that there are relatively few differences in the MDD phenomenology for adults and younger and older adolescents.

Gender Differences. The next question we addressed was whether patterns of MDD symptoms in girls and boys differ. Among OADP participants with MDD (269 girls and 123 boys), prevalence rates of two of the nine symptoms were significantly different. Compared to depressed boys, depressed girls more often reported weight/appetite disturbance (77% vs. 58.5%) and worthlessness/guilt (82.5% vs. 67.5%). These differences may indicate a slightly different focus for treatment of depressed adolescent girls versus boys.

Epidemiology

Data from the OADP provide estimates of the basic parameters of MDD epidemiology. These parameters include the percentage of adolescents in an episode of MDD at a given point in time (point prevalence), the percentage of adolescents who have experienced an MDD episode during their lifetime (lifetime prevalence), and percentage of adolescents who are not depressed at the beginning of an observation period but who develop an MDD episode during a specified period of time (incidence). In our case the incidence is one year. Incidence rates are customarily divided into first incidence (percentage who develop an MDD episode for the first time during the incidence interval) and recurrence (percentage with a previous episode of MDD who developed another episode during the interval). From a public health perspective, the total incidence rate is important for planning the delivery of mental health services in that it indicates how many individuals in the population will become depressed during a certain time period. This data is presented in Table 3.

TABLE 3

Prevalence and Incidence Data of Major Depressive Disorder in Adolescents

	Total Sample	**Females**	**Males**
Adolescents depressed at the initial interview	2.6%	3.4%	1.7%
Adolescents depressed at the second interview, 1 year later	3.1%	3.6%	2.6%
Adolescents who have ever been depressed (Lifetime Prevalence)			
At initial interview	20.4%	24.8%	11.6%
At second interview	24.0%	31.6%	15.2%
Adolescents who become depressed between the first and second interviews			
Total incidence	7.8%	10.4%	4.8%
First incidence	5.7%	7.1%	4.4%
Recurrence	17.9%	21.1%	9.1%

As can be seen in Table 3, depression is surprisingly common in adolescence. Lifetime prevalence rates of MDD for the OADP participants are especially high. Prorating our results, we estimate that approximately 28% of adolescents will have experienced an episode of MDD by age 19 (35% of young women and 19% of young men). Before discussing these rates further, the possibility needs to be considered that these values are somehow inflated. Potential causes of artificially high depression rates could include (a) over diagnosis by our interviewers, or (b) lack of clinical significance to the enumerated episodes even if they technically met diagnostic criteria. To evaluate these possibilities, we asked child psychiatrists to rate the clinical significance of our cases by reviewing the written summaries. Results indicated that the identified cases met criteria but few were severe: 21% mild, 42% between mild and moderate, 29% moderate, 7% between moderate and severe, and 1% severe.

MDD Onset. Mean age of MDD onset was 14.9 years. The rates of depression onset in childhood are low, doubling from an annual incidence rate of 1% to 2% at age 13 and from 3% to 7% at age 15. Earlier onset MDD was associated with being female, lower parental education, the presence of other co-occurring psychiatric conditions, and a history of suicide attempt.

Duration and Recurrence. Mean duration of depressive episodes was 26 weeks, with a range of 2 to 520 weeks. Longer episodes were associated with earlier onset (at or before the age of 15), suicidal ideation, and seeking mental health treatment. Of the adolescents who recovered from the depressive episode, 5% experienced another episode within 6 months, 12% within 1 year, and approximately 33% within 4 years. Shorter time to recurrence was associated with prior suicidal ideation and attempt, and with later first onset. Formerly depressed females were more likely to have another episode during the two assessment points, although the mean time to recurrence for females and males who relapsed did not significantly differ.

Impact of Gender and Age on MDD. Gender differences in the rate of adult depression have been reported many times, with a typical ratio of 2 to 1 (women to men). Conversely, most studies of pre-adolescent children find no gender difference in rates of depression or a slight elevation in boys compared to girls. We found a significant gender difference with females being twice as likely as males to be depressed. The effect of age and the interaction of age and gender, however, were nonsignificant. Comparing our results with other studies suggests that the gender difference in MDD levels probably emerges in the relatively small window between the ages of 12 and 14.

> ***Depression in the adolescent population is a major mental health problem that is often under-recognized.***

The Occurrence of Suicidal Behavior. Given our focus on depression, occurrence of suicidal ideation and suicide attempts has been an area of particular interest. Consistent with other studies, we found that suicide attempts almost always occur in the context of significant psychopathology. For example, 96% of the adolescents who made a suicide attempt between the first and second assessment points had a concurrent diagnosis (100% of the boys and 94% of the girls). Suicide attempts were most highly associated with MDD, alcohol and drug use disorders, disruptive behavior disorders, and, to a lesser extent, anxiety disorders. Likelihood of a suicide attempt increases greatly given the presence of multiple psychiatric disorders. Among depressed adolescents, 41% had suicidal ideation (43% females and 39% males). Suicidal ideation was associated with chronic, long-lasting and recurrent MDD episodes. Twenty-one percent of the adolescents with MDD reported a past suicide attempt (22% females, 18% males).

Treatment

Our research with the OADP indicates that 61% of community adolescents with MDD receive some type of treatment, although it typically is quite brief. The modal form of treatment was seven or fewer sessions of outpatient individual psychotherapy administered by a mental health provider. Factors that increased the likelihood of treatment utilization include greater depression severity, the presence of a co-morbid disorder, previous history of depression, suicide attempt, academic problems, not residing in an intact family, and being female.

What Stimulates Treatment Seeking? To determine the factors leading to treatment utilization, we compared participants in a clinical trial consisting of 96 adolescents meeting DSM-III-R criteria for MDD or dysthymia with 42 non-treated depressed adolescents from the OADP data set. Although both groups met diagnostic criteria for MDD, adolescents who received treatment had significantly higher scores on the Hamilton Depression Rating Scale, greater levels of major stressful events, heightened self-consciousness, less social self-confidence, less perceived social support from their friends, and more conflicts with parents. These findings suggest that treatment seeking for depressed adolescents is triggered by stressful life events in the context of low social embeddedness. In other words, in addition to the severity of the depressive episode, the circumstances surrounding a depressive episode appear to determine whether or not treatment for the depressed adolescent is sought.

What do Depressed Adolescents Want from Therapy? As part of the intake interview, the depressed adolescents from the clinical trial and their parents independently described the specific difficulties they most wanted addressed in therapy. The four most common complaint categories reported by teenagers were dysphoric mood (45%), poor self-esteem (33%), interpersonal difficulties (e.g., problems with peers at school, conflict with parents, 32%), and decreased effectiveness/coping (32%). The same four problem categories were also most frequently reported by the parents (percents were 33%, 62%, 38%, and 54%, respectively). While the treated boys and girls did not differ on the average number of reported target complaints, girls reported significantly more problems with poor self-esteem than boys (42% vs. 21%), whereas boys reported significantly more problems with reduced effectiveness and coping than girls (39% vs. 21%).

Conclusions and Recommendations

We want to end by summarizing some of the conclusions and recommendations that we believe are justified by our findings. First, the magnitude of adolescent depression (prevalence, but especially incidence) is much larger than had been thought. Depression in the adolescent population is clearly a major mental health problem that is often under-recognized. Second, depression during adolescence is associated with numerous negative psychosocial consequences. Depression seriously interferes with effective functioning. Depression causes suffering and impairment; because of this, depressed adolescents are in need of help especially during, but also before and after the episode.

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This article has been condensed from P.M. Lewinsohn, P. Rohde, and J.R. Seeley. (1998). Major depressive disorder in older adolescents: Prevalence, risk factors, and clinical implications. *Clinical Psychology Review*, 18(7), 765-794. Copyright © 1998, with permission from Elsevier Science.

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Depression and Substance Use Disorders in Adolescents

By Uma Rao, M.D.

Adolescence is a very high risk period for the development of both depressive illness and substance use disorders (namely, alcohol and/or other drug abuse). Epidemiological surveys have indicated that up to 5% of youngsters develop depression or substance abuse each year. Also, the frequent co-occurrence of depression and substance use disorders during this developmental period has been demonstrated in both clinical and non-clinical populations; 30% to 50% of depressed youth also report substance abuse problems.

Adolescent depression is often associated with significant psychosocial dysfunction, and this is true of substance abuse as well. When these two disorders are comorbid, adaptive function is further compromised. The co-occurrence of substance abuse with depression in adolescents is associated with earlier onset and more severe alcohol/drug-related problems, more prolonged depressive episodes and increased frequency of behavioral problems, more severe impairment in interpersonal and academic competencies, increased utilization of mental health services, as well as elevated risk for suicide. Given the economic and psychosocial burden associated with co-occurring depression and substance abuse, the identification of risk factors associated with their comorbidity is of great public health importance. In order to examine the underlying mechanisms involved in the risk for comorbidity between depression and substance abuse, data that were gathered in our laboratory will be summarized.

Associations Among Depression, Substance Abuse and Life Stress in Adolescent Females

Using a longitudinal design, the study assessed the onset and clinical course of, and psychosocial risk factors for, major depression and substance use disorders in a sample of 155 senior high school females during the post-high school transition. Using standardized diagnostic instruments, the women were followed from the time of high school graduation for a period of 5 years. Follow-up assessments were conducted at 6-month intervals during the first year, and annually thereafter. Diagnoses were made by consensus group ratings by raters who were "blind" to the prior diagnostic status.

Information on stressful life experiences was obtained by a standardized interview at baseline and at each follow-up appointment. The information was presented to trained raters who were blind to the subject's diagnostic status and perception of the event. Consensus group ratings were made on the impact of the life events. Symptom-related events were not coded.

The mean follow-up interval was 4.5 years. 86% of the sample had four or more years of follow-up, and 72% were interviewed at every time-point.

Demographic Characteristics. The mean age of the sample at study entry was 18.3 years (ranging from 16.7 to 19.6 years). At the end of the follow-up period, the mean age of the sample was 22.8 years. Caucasians constituted 45.2% of the sample; 1.9% were African American; 21.3% were Hispanic; 9% were Asian; and 22.6% multi-racial or of other ethnic origin. The women were primarily of middle socio-economic status.

Substance Abuse. At the time of initial study, the lifetime prevalence of substance abuse was 9.7%. Of 150 women providing follow-up information, 21 (14%) reported one or more episodes of substance use disorder during follow-up. Of these, 13 had a first episode, yielding an incident rate of 9.6% over 5 years. Substance abuse diagnosis before the study predicted substance abuse during follow-up, suggesting a strong continuity from adolescence to young adult life; 53% of women with prior substance abuse had substance abuse diagnosis during follow-up compared with 9.6% of those without prior substance abuse.

Concurrent Relationship between Depression and Substance Abuse: At baseline, women with depression were more likely to have substance abuse than women without depression (18.2% and 6.3%, respectively). The two disorders were also significantly related during follow-up (21.1% of women with depression also had substance abuse, whereas 7.6% of women without depression experienced a substance abuse episode). Depressive and substance abuse episodes occurred in close temporal proximity to each other; the time interval to the onset of first major depressive episode and interval to the onset of first substance abuse episode during follow-up, as well as the proportion of days spent in depressive and substance abuse episodes, were correlated.

Longitudinal Association between Depression and Substance Abuse. After controlling for the effects of prior depression, presence of substance use disorder during adolescence increased the likelihood of developing major depressive episode(s) during the transition to adult life. In women without substance abuse, the probability of developing depression during follow-up was 17% within 1 year, 26.8% within 2 years, 31.7% within 3 years, 42.9% within 4 years, and 48% within 5 years. In women with substance use disorder, the probability of depression was 33.6% within 1 year, 61.5% within 2 years, 71.1% within 3 years, and 81.9% within less than 4 years.

Women who had prior substance abuse were more likely to have a shorter time to the first major depressive episode during follow-up than women who developed substance abuse during the study, suggesting that the effect of substance abuse on depressive episodes is more robust over time than its immediate effect. After controlling for initial substance abuse, depression prior to the study did not significantly increase the likelihood of developing substance use disorder during follow-up.

Social Adjustment in Women Who Had Substance Abuse During Follow-up: In comparing women who had an episode of substance use disorder during follow-up with those who did not have a substance abuse episode on interpersonal (including family, peer and romantic) relationships and occupational (school and work) functioning, women with substance abuse had greater impairment in romantic relationships, and in school and work domains. Longer duration of substance abuse problems was associated with greater academic impairment, including poor school performance and disciplinary problems.

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Relationship between Stressful Life Experiences and Substance Abuse. In order to assess whether recent stressful life experiences precipitated substance abuse episodes, impact of life stress in the 3-month period prior to the onset of the first substance abuse episode during follow-up was calculated. In women who did not have a substance abuse episode, the magnitude of stress over a mean 3-month period was taken. The two groups were compared on the stress impact. Women with a substance abuse episode had higher levels of stress than women who did not develop substance abuse. This was true in both depressed and non-depressed groups.

Relationship Between Stress-Response System & Risk for Substance Use Disorder in Depressed Adolescents

In a longitudinal study, the magnitude of risk for substance abuse was evaluated in a clinical sample of depressed adolescents who never had any substance use problems prior to recruitment into the study, and a group of normal volunteers who had no evidence of any psychiatric disorder at baseline. Also, potential clinical and biological factors associated with risk for substance abuse were examined.

Both groups were comparable on the age of initiation of alcohol/drugs, first experience of intoxication and regular use. The depressed group, however, was more likely to progress to substance abuse at an earlier age than were the controls. Progression to substance abuse in the depressed group occurred, on average, 1.5 years from the time of first use. In the controls, this interval was 3.3 years.

Similar to the observation in the first study, substance abuse occurred in close proximity to depressive episodes, prior to the remission of the index depressive episode in the depressed group, suggesting that when depressed youngsters resort to alcohol or drugs (possibly for alleviating distress), this rapidly progresses to abuse. Even among the controls, the onset of depression and substance abuse occurred in close proximity to each other.

Using clinical and biological measures that were obtained at the time of initial recruitment (prior to the development of substance abuse), factors associated with vulnerability to substance abuse were examined in the depressed sample. A more prolonged depressive episode and presence of anxiety disorder were associated with increased risk for substance abuse. Also, depressed adolescents who developed substance abuse had higher levels of cortisol, a hormone that is a component of the body's stress-response system, compared with depressed adolescents who did not develop substance abuse. The elevated cortisol was particularly evident around bedtime, a time when the system is normally less active, possibly suggesting increased physiological arousal.

Interpretation of the Results

These data suggest that depression and substance abuse problems co-occur frequently during adolescent and early adult years, with episodes of both disorders occurring in close temporal proximity. Substance abuse also predicts depression over time. Specifically, if depressed individuals resort to alcohol/drug use as a coping mechanism for alleviating depressive symptoms (or in response to stressful situations), substance use might ultimately worsen depressive illness. Progression from initiation to onset of substance abuse might occur more rapidly in depressed persons. Because the effects of substance use on depression occur relatively late, such individuals might not be able to recognize the detrimental effects of substance(s) on mood regulation.

Based on data from these two studies and from the literature on animals and adult humans, it appears that environmental stress and stress-response systems are closely associated with vulnerability for substance abuse. Developing and testing interventions that focus on these factors might be helpful in more effective treatment and prevention of substance abuse.

Dr. Uma Rao is with the Department of Psychiatry and Biobehavioral Sciences, and the Brain Research Institute, UCLA School of Medicine. Support for Dr. Rao was provided in part by the Scientist Development Award (MH01419) from the National Institute of Mental Health.

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Self-Injury Q&A

with Dr. Tracy Alderman

Editor's Note: Due to the overwhelming interest in our issue on adolescent self-injury, we are pleased that Dr. Tracy Alderman, author of "Helping Those Who Hurt Themselves" (*The Prevention Researcher*, 7(4), pp. 5-8) and *The Scarred Soul: Understanding & Ending Self-Inflicted Violence* (New Harbinger, 1997) has agreed to the following Q&A session. The following questions were posed by you, our readers, via our web site (www.TPRonline.org).

Q. I am a high school counselor and it seems that we currently have quite a few students engaged in cutting behaviors. Can you make a recommendation regarding the best response a school can take when confronted with a cutting student? It seems that some are reported and get some treatment and yet others are deemed "not as serious" by our social worker. My understanding is that all cutters should be taken seriously. Can you comment in a general way?

A. Cutting often signifies that a person is enduring great emotional pain. The behavior of cutting is sometimes used as a way of releasing that emotional distress. When schools are confronted with students who cut themselves, several steps should be taken. First and foremost, make sure that the student is okay medically and that no further medical attention is necessary. Next, school staff should talk with the student and learn as much as possible about the cutting behaviors and what is behind them. Sometimes the parents of the student should be notified and consulted about their child's behavior, but this really depends on the circumstances and the family dynamics. While there isn't one set approach to dealing with students who hurt themselves, it's important to realize the intensity of their feelings and be willing to listen and offer support to the student.

Q. When one feels the urge to self-injure, is there any key phrase, or such, they can be taught to remember and use as an automatic response, to possibly diffuse the desire?

A. It would be great if there were a magic word like "abracadabra" which could take away the desire to self-injure. Unfortunately, there's not. Once people get the urge to self-injure the best thing that they can do is to change their behaviors. If they typically hurt themselves in isolation, have them go somewhere where there are others, like a mall or a restaurant. Also, it's nice to have an available list of alternatives to self-injury. This list should be made before the desire to self-injure is present and should include at least five things to do other than self-injure. Once a person does all five things (or more) on this list, chances are the urge to hurt him or herself won't be as strong.

Q. In my experience, self-mutilation is a response to emotional pain. One would rather feel physical pain than the degree of emotional pain they are feeling. I believe that such people haven't been taught healthy ways of dealing with emotionally stressful situations. Do you agree and do you have suggestions for healthy ways of dealing with emotional stress?

A. I totally agree with you that self-injury is a response to emotional pain. In essence, self-injury is just a coping mechanism that some people use to deal with intense emotional distress. Learning alternative ways to deal with these overwhelming feelings will help to decrease the incidents of self-injury. Each one of us has different methods of coping with stress and other negative emotions. Some people try to cope by using methods which aren't all that healthy, like using drugs or alcohol, overeating, gambling, smoking, or spending too much money. Some of the healthier ways of coping include things like talking with someone, exercising, sleeping, writing, and drawing. However, any coping mechanism can become problematic if it's taken to the extreme. For example, someone who exercises ten hours a day to deal with stress is probably going a bit overboard and may actually be harming him or herself physically. The basic idea behind coping mechanisms is to find one (or several) which make you feel better and aren't going to hurt you in the process.

Self-injury is a response to emotional pain.

Q. A friend of mine just told me she is a cutter and so is her best friend. What can I say to them, and how do I not sound like a mother?

A. Learning that a friend self-injures can be really difficult. The best thing that you could do is simply to listen. Talk with your friend about why she is hurting herself and what's happened before she cut. By offering your support and continued

(Continued on Page 3)

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From the Editor's PC

Dear Colleagues:

I am pleased to welcome you to our fourth Resource Issue. This is our annual supplement to the quarterly *Prevention Researcher* which gives us the opportunity to offer you some additional prevention material.

This Resource Issue includes book reviews, Internet resources and sites, and two unique interviews with leading specialists in the field of prevention. Our book reviewers for this issue are: Jeffrey L. Derevensky, Ph.D., from McGill University; Farzana Doctor, M.S.W., and Lyndsey Davies, M.S.W., both from the Centre for Addiction and Mental Health in Toronto; and Faedra Lazar Weiss, M.A.H.L., from Girls Incorporated.

As a unique feature to this issue, we have two exclusive interviews with leading figures in the prevention/intervention community. Dr. Tracy Alderman, a psychologist and adjunct instructor at Chapman College answers questions about self-injury posed by you, our readers. Also, I was fortunate to have the opportunity to interview Andrew Weil, M.D., a best selling author and director of the Program in Integrative Medicine at the University of Arizona. Both interviews are informative and will hopefully be useful to all our readers.

On a personal note, let me express my sympathy to the victims, survivors, and extended family of those impacted by the terrorist attacks. We have all been touched by this trauma. I would like to ask all of my colleagues in the prevention community to continue giving time, energy, and resources to the organizations that are involved with the relief efforts. If you can't give of your professional services, I ask that you make a contribution to the Red Cross or other charities that are supporting the victims. All of us at *The Prevention Researcher* are deeply saddened by this tragedy and want to be part of the healing process.

As always, our web site (www.TPRonline.org) is also a source for resources. Please feel free to visit us there and send us comments if you wish.

Have a safe winter!!!

Steven Ungerleider, Ph.D.
Psychologist/Editor
The Prevention Researcher

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Recycled Paper

Self-Injury Q&A *(Continued From Page 1)*

friendship you're giving your friend an incredible gift. Also, try to remember that you really can't do anything to change your friend's behaviors. If she wants to hurt herself, you aren't going to be able to stop her. All that you can do is be there for her and hopefully your friendship and support will help lessen her need to cut herself.

Q. As an editor of a youth prevention magazine, I am curious why self-injury is becoming more prevalent among today's teenagers. It seems local counselors and healthcare professionals are witnessing more and more "cutting" cases in young people ages 12 to 18. Do you think it has something to do with all the media attention on the subject?

A. It's hard to know if self-injury is becoming more prevalent or if it just seems so because more people are talking about it. Because it's typically such a secretive behavior, obtaining a good estimate on how many teenagers are self-injuring is nearly impossible. I think the recent media attention on self-injury has made people feel better about talking about it with others. Now people who injure themselves can see from the media that they aren't the only ones doing this, that they aren't freaks or crazy. By knowing that there are others out there doing the same thing, individuals who self-injure may be beginning to have the courage to come forward and talk about their behaviors and try to get some support and help.

> ***Obtaining a good estimate on how many teenagers are self-injuring is nearly impossible.***

Q. I am a school counselor and I work with elementary-aged students. We have a class of 6th graders who have been participating in a form of self-mutilation. They are using pencil erasers to "burn" themselves. They rub the erasers on their skin until the skin is gone. I can't understand why they're doing this. I feel that it's peer pressure more than anything. What approach should I take in discouraging the students from this behavior?

A. A long, long time ago, when I was in 6th grade, my friends and I used to participate in a "game" in which we would grab the other's forearm with both hands and twist the skin in opposite directions. The idea was to see how much pain the other person could handle. By the end of this "game" we would each have extremely red forearms that could ache for hours. In our 6th grade minds, this was extremely fun.

I agree with your assessment that the students in your school are doing this based on peer pressure and in their minds this is something fun to do. Although as a counselor this may be very distressing to observe, it's probably not very dangerous and it's probably something that they will soon give up, replacing it with another "game."

In the meantime, I'd suggest talking with them about their reasons for participating in this activity and maybe suggesting some alternative "games." It may be that they simply need something to do with their hands while they're in class. You may want to suggest that the teacher finds a suitable substitution, like coloring, drawing, or playing with a Koosh ball.

Q. How do you help a self-injurer who has stopped cutting but continues engaging in other self-destructive behaviors?

A. Self-injury is usually just a symptom of an underlying problem. Without treating the problem, symptoms will continue to occur. It's really common for someone who gives up self-injuring without getting help for some of the underlying issues to develop other types of self-destructive behaviors (some of which may be much more dangerous than self-injury). I'd suggest getting some help via therapy or counseling to deal with the underlying issues that are creating such distress.

Q. How can we raise awareness about self-inflicted violence?

A. In the past five years, awareness of self-inflicted violence has grown tremendously. More and more people are talking about self-injury and helping to dissolve the secrecy and shame surrounding it. The best way to raise awareness about self-inflicted violence is to keep addressing the issue, continue talking about it, and persist in educating others through the media and personal contact. ⤳

Tracy Alderman, Ph.D., is a licensed clinical psychologist in San Diego, California. She is an adjunct instructor at Chapman University and an educational research specialist with San Diego city schools. Her books include *The Scarred Soul: Understanding and Ending Self-Inflicted Violence* (New Harbinger Publications, 1997) and *Amongst Ourselves: A Self-help Guide to Living with Dissociative Identity Disorder* (New Harbinger Publications, 1998).

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Women Living with Self-Injury

By Jane Wegscheider Hyman, Ph.D.
Reviewed by Faedra Lazar Weiss, M.A.H.L.

1999. Philadelphia, PA: Temple University Press.
ISBN: 1-56639-720-0 (cloth); 1-56639-721-9 (paper)

Most people have purposely injured themselves at some time in their lives. Think of the irresistible impulse to run one's tongue over a cold sore or slamming a fist into a wall in frustration or anger. Most people would feel relief when the sore healed or decide that skinning and bruising their knuckles once was enough. However, for some individuals, injuring themselves becomes a sort of addiction. They depend on repeated and often escalating self-injury to function relatively normally in the larger world.

Little research has been conducted on self-injury. In a culture in which most personal predilections and failings are discussed openly, people who self-injure often go to great lengths to hide their behavior and its consequences. Dr. Hyman brings us into the experiences of fifteen women willing to talk about "the last secret"—cutting, burning or battering their own bodies. All of the women included in this volume are European American, in their mid-20's to early 50's and work outside of the home. Several are also students. Some have children; some do not. Some are lesbian, some straight, and some cannot imagine voluntarily participating in any sexual relationship. The author presents their stories in their own words, some at length, others in shorter vignettes. Her analysis shows the common threads and also the uncommon ones.

One thread running through all fifteen stories is child abuse. Every woman telling her story lived through severe sexual and/or physical abuse perpetrated by one or more people she should have been able to trust above all others (almost always parents or other close relatives). A related thread is difficulty in expressing anger. Even in dreams and fantasies, these women rarely can imagine confronting their abusers, let alone harming them in return. Instead, they harm themselves.

Another common thread is secrecy. A few of the women have been able to reveal their physical and emotional scars to a few chosen people, but most fear repercussions at home or at work, and with good reason. Women with children do not want to frighten them or to inadvertently encourage their children to injure themselves. Some partners refuse to tolerate self-injury; others believe they should be able to change a partner's behavior. The women who work as counselors or social workers agonize over whether to confront colleagues who make fun of "cutters" or who treat all self-injury as if it were an active suicide attempt. Women in other jobs fear that colleagues will be disgusted by their actions or will decide for them whether or not to intervene in a situation that invites self-injury.

Perhaps the greatest service of this volume is showing that each woman injures herself for different reasons and similarly needs and deserves unique support in moderating her self-injury or stopping it altogether. Dr. Hyman compiles 25 reasons that the women she interviewed gave for injuring themselves, some of them seemingly contradictory: to escape reality or to bring oneself back into reality; to punish themselves or to cry for help. Some of the women found a contract with a therapist or important friend not to self-injure helpful in fighting the need to self-injure; others found it insulting. Some preferred that friends or family acknowledge new injuries; some needed reassurance that others would act as if nothing had happened. Some benefited from support groups including other women who self-injured; others preferred more generic support groups, and one woman concluded that the only way she could stop self-injuring was to rely on herself alone. A resource list includes the wide variety of resources that one or more women found helpful.

Women Living with Self-Injury is written in plain language and will be of use to many audiences. Women who self-injure, their families, friends, colleagues, and lay and professional counselors will find insights and resources. As Dr. Hyman properly notes, this book should be approached with caution. Readers may need to skip graphic descriptions of self-injury and child abuse or to limit the amount they read at a sitting. Women who have lived with these realities may reawaken painful memories or feel the need to injure themselves as they read the experiences of others. They may want to read this volume, if at all, with a trusted friend or counselor.

> ***Perhaps the greatest service of this volume is showing that each woman injures herself for different reasons and similarly needs and deserves unique support.***

This book is not the last word on self-injury. The term "self-injury" itself is chosen from among inadequate alternatives. Dr. Hyman notes areas that deserve much more research: the stories of women of color, and men, who self-injure; the similarities, differences, and overlaps between self-injury and forms of body decoration such as tattooing, branding, piercing, and scarification; and religious traditions that support or encourage afflicting or injuring one's body, as well as further research among European American women. One hopes to see some of these areas addressed in works of this caliber by Dr. Hyman or colleagues inspired by her research.

The author, Jane Wegscheider Hyman, Ph.D., is a researcher and writer on mental and physical health, specializing in mental health problems that primarily afflict women. Her other works include *The Light Book* and, with others, *Sacrificing Ourselves for Love; Ourselves, Growing Older;* and *The New Our Bodies, Ourselves.*

The reviewer, Faedra Lazar Weiss, M.A.H.L., is Research Associate at the Girls Incorporated National Resource Center. She is co-author of "Prevention of Sexual Intercourse for Teen Women Aged 12 to 14" (*The Prevention Researcher*, 1997, Vol. 4(1), pp.10-12) and of numerous publications on issues affecting the lives of girls and young women. She is a member of the editorial board of *The Prevention Researcher.*

An Interview with Dr. Andrew Weil

By Steven Ungerleider, Ph.D., Editor

The Prevention Researcher was recently honored to interview Dr. Andrew Weil regarding holistic health and prevention. Dr. Weil, a Harvard trained physician, is the author of eight books, including two *New York Times* best sellers, *Spontaneous Healing* and *8 Weeks to Optimum Health*. He has been featured in PBS documentaries, *The New York Times*, Prime Time Live, and CNN-Larry King Live. I spoke with him from Tucson, Arizona, where he directs the Program in Integrative Medicine at the University of Arizona Health Sciences Center.

Editor: Dr. Weil, let me jump right in and ask you about your notion of health and healing as it relates to high-risk youth. In your pre-eminent book, *Spontaneous Healing*, you comment that the "more we acknowledge and favor the internal healing system of our bodies, the greater health we will experience in every aspect of our lives." How can you relate this concept to at-risk youth?

Dr. Weil: The healing potential of the body declines with age. In young people it is high—their wounds heal quickly and illnesses tend to come and go quickly. At-risk youth are likely to take all this for granted and imagine that it will always be like this for them. But in order to maintain the body's healing system and ensure that it will continue to work well as you age, you have to take care of it. The earlier in life you begin to be aware of how the body works and how to treat it well, the better the chance that it will continue to serve you well throughout life. The fact is that much high-risk behavior undermines the healing system.

Editor: What do you consider to be the greatest health threat to at-risk youth?

Dr. Weil: I would say the common belief of young people that they are invulnerable, that calamities like heart attacks, cancer, and hip fractures from weak bones are remote possibilities that could not possibly affect them. The truth is that these diseases arise from years of unhealthy living that begin in youth. Because young bodies are so resilient, young people tend not to see the cause and effect connection between unhealthy habits of nutrition, exercise, rest and sleep, and the diseases that can arise from them. At-risk youth need to understand that the lifestyle choices they make now can and will affect them later in life.

Editor: How can a medical practitioner – especially someone using integrative approaches as opposed to traditional medical approaches – become more involved in prevention when working with youth?

Dr. Weil: Integrative medicine looks at whole persons – bodies, minds, and spirits – also at community and environmental influences on health, and at total lifestyle. It also puts a much greater emphasis on prevention than standard medicine. Integrative practitioners will naturally be better equipped to take a preventive approach when working with youth because they will be able to see the root causes of health problems and be able to suggest more varied and more innovative strategies for modifying them.

Editor: How can the family doctor or general practitioner get more involved in the prevention and intervention of high-risk behaviors in the school environment that can lead to serious health consequences?

Dr. Weil: The first step is to identify the behaviors. The next step is to look at the total picture of causation, not just in the school environment, but in homes, in communities, and in society at large. For example, if tobacco use is identified as a problem, it is not just use in and around the school that influences it. Family doctors also need to work at the level of social and political action as well. The American medical profession, in general, has been remarkably silent and inactive in many areas that affect the health of youth—nutrition, for example, and environmental toxicity.

Editor: One notion that I believe in (and I know you have written about) is that you must take care of yourself before you can help others. Many readers of *The Prevention Researcher* work in stressful and chaotic environments. What are some ways that they can deal with this stress so they can better serve the youth around them?

Dr. Weil: There are many ways to neutralize the harmful effects of stress on the mind and body. The most time- and cost-effective way I know is simple breath work. Practicing breath control can dramatically alter physiology, control anxiety, and promote health. I've given detailed instructions for this sort of practice in my books, newsletter, web site (www.drweil.com), and on a recent audiotape. Of the many recommendations I've given to patients over the years for self-care, the one that I have gotten the most positive feedback for, is breath work. Most of us have never been taught how to breathe properly, and this subject is still not included in the training of most doctors. It is strongly emphasized in the Program in Integrative Medicine at the University of Arizona.

> ***The healing potential of the body declines with age.***

Editor: Two issues that we have focused on in *The Prevention Researcher* are eating disorders and self-inflicted violence. How would you approach these two related issues from an integrative medicine point of view?

Dr. Weil: Again, it's a matter of comprehensive diagnosis and comprehensive treatment. That means looking at all the causes: physical, emotional, spiritual, environmental, and societal that produce these behaviors and recommending strategies for dealing with all of them. For example, the prevalence of eating disorders in young American women cannot be separated from the messages coming from the fashion and entertainment industries about desirable body types, and the prevalence of self-inflicted violence is part of the general problem of violence in our society and its visibility in the entertainment media. Boosting self-esteem and teaching methods of stress reduction would be central to my approach to these problems. I might draw on specific mind/body treatment methods, such as hypnotherapy and guided imagery therapy.

Editor: We have recently discussed the serious health consequences of teenage tobacco use, both smoking and spit tobacco. Many adolescents are already addicted to tobacco and want to quit. What are some suggestions for health care professionals who want to assist these youth in tobacco cessation?

Dr. Weil: Motivation is the key to breaking any addictive behavior. The problem for the health care professional is that you cannot put motivation into another person. All you can do is help the user get to the point where motivation is sufficient. Urging tobacco users to set a date to attempt to quit is key. Making them aware of treatment strategies to support the attempt will help—everything from acupuncture to nicotine gum to hypnosis. The most important suggestion might be to try to convince youth that tobacco is going out of fashion—that it is not cool or attractively deviant anymore.

Editor: Homeless and street youth lead unstable and hazardous lives. They are at high risk for alcohol and drug use, HIV infection, and many other health related disorders such as asthma, pneumonia, and trauma. Are there basic concepts from integrative medicine that can be useful in guiding health care professionals when working with street youth?

Dr. Weil: I'm a great believer in education – in giving people truthful information and letting them use it to their own advantage. However unstable and impoverished are the lives of these youth, they can understand the risks of dirty needles and the simple precaution they can take to avoid the worst (i.e., lethal) consequences of their high-risk behaviors. It may be impossible in our present society to make these problems disappear. All we can do is give out the best information we have and hope that people at high risk will use it as their circumstances allow.

Integrative medicine calls for true partnership between doctor and patient.

Editor: How can medical practitioners get more involved with mentoring at-risk youth? Is this even a possibility?

Dr. Weil: One possibility is online mentoring. There are new experimental programs to connect at-risk youth with mentors via the Internet. I participate as a mentor in one of these programs, The Digital Heroes Campaign, that was organized by *People* magazine and America OnLine. Various groups are interested in developing this movement. The time commitment on the part of the mentor is not great, and I think medical practitioners might find it very rewarding. Information on the People-AOL project is available online (at www.mentoring.org).

Editor: Dr. Weil, in most of your books, you focus on "wellness and healthy interventions for the adult." Is there a population, perhaps at-risk youth, that could benefit from a "holistic intervention" and shift in lifestyle with some early understanding of prevention and healthy lifestyle decisions?

Dr. Weil: Definitely yes. I do not think it would take a lot of effort to adapt the philosophy and specific recommendations in my books to young people in general and at-risk youth in particular. One of my future projects is doing a book for young people on preventive health maintenance. I'm thinking of aiming it at kids in the 10-12 age range, but I think the material could be reworked for both younger and older children. This is something I'm passionate about, as I believe the younger the age at which the concept of preventive health maintenance can be instilled, the better. I'd be happy to support work in this area.

Editor: In your book *Spontaneous Healing* you devote a full chapter to the 8-week program for healing power. You address projects, diet, supplements, exercise, mental, spiritual, and healthy choices. Could all or some of these weekly regimens be applied to teenagers struggling with peer pressure and societal challenges?

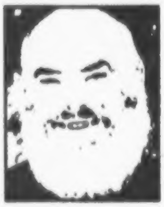
Dr. Weil: The 8-week program of *Spontaneous Healing* was expanded in a following book, *8 Weeks to Optimum Health*. Many thousands of people have now gone through that program with good results. Many of them did it at their own pace or modified it to suit their particular circumstances, which is fine. Each year, large virtual groups form on my web site to do the Program. This turns out to be very successful, with participants forming real online communities and giving each other group support. I've known a number of teens who have done it, and I think it would be possible to take teen groups through versions of it, either online or offline.

Editor: In other literature you have discussed the problems with "traditional medicine" and the basic "mistrust" that some patients have about seeking medical advice. Your prescription for change is to change the way doctors communicate with patients. Could a curriculum be designed in K-12 schools that addresses the relationship of patient to doctor, student to mentor?

Dr. Weil: Yes. I think change has to come on both sides. The traditional, authoritarian, paternalistic stance of medical professionals is an obstacle to the change I'd like to see but so is a passive, non-participatory attitude of the patient or student. Integrative medicine calls for true partnership between doctor and patient. The doctor is a teacher or guide and should also be a good role model for healthy behavior. The patient must accept responsibility for his or her own well-being. I'm working on the medical education side of things, trying to train a new generation of doctors who understand the new relationship. It would be great to see a school curriculum that works on the other side.

Editor: Finally, what are the things that we as mental health professionals can be doing to better educate our colleagues in the area of prevention? What can we do that will allow us to be more effective in our work with high-risk youth, around healthy lifestyle choices and getting help early on in the process?

Dr. Weil: I'd go back to taking responsibility for your own well-being. The more that you can inform yourselves about and put into action the concepts of preventive health maintenance and healthy lifestyles, the more you will be able to influence others—both colleagues and clients—in the right direction. ✤



Andrew Weil, M.D., is a graduate of Harvard Medical School. He currently teaches at the University of Arizona in Tucson, specializing in alternative medicine, mind/body interactions and medical botany. He is the founder of the Program in Integrative Medicine at the University of Arizona Health Sciences Center in Tucson. He is also the author of eight books. His most recent is *Eating Well for Optimum Health: The Essential Guide to Food, Diet, and Nutrition* (Knopf, 2000).

Steven Ungerleider, Ph.D., is a licensed psychologist and editor of *The Prevention Researcher*. He is the author of four books, most recently *Faust's Gold: Inside the East German Doping Machine* (St. Martin's Press, 2001).

Book Review

Straight Talk About Teenage Gambling

By Carol Silverman Saunders

Reviewed by Jeffrey L. Derevensky, Ph.D.

1999. New York: Facts On File, Inc.
ISBN: 0-8160-3718-3

This is a well written book that provides adolescents with concise, up-to-date information about gambling. It examines the increasing accessibility of gambling by youth and the factors that prompt them to engage in and maintain this behavior in spite of repeated losses. The author provides excellent definitions of non-gamblers, recreational gamblers, serious gamblers, problem gamblers, compulsive gamblers, and professional gamblers.

Throughout the book, the author provides indices of risk-factors, the types of gambling particularly attractive to today's youth, how to resist peer pressure, and how to exercise self-control. Particularly noteworthy is the discussion of advertisements (television, radio, print), which state lottery corporations and casinos use to lure individuals to gamble. While lottery corporations do not necessarily target youth, many of the products advertised are particularly attractive to this age group. Ample research shows that while prohibited by law, many underage youth actively purchase lottery tickets (in particular scratch tickets) and are given lottery products by their parents. The author further notes that lottery advertisements are the only form of advertising to which state and federal truth-in-advertising standards do not apply.

If youth are going to engage in this behavior, can we teach them how to do it responsibly?

The fact that our youth gamble is inevitable. For many adults, the negative associations and connotations previously attributed to gambling are now gone. Gambling is no longer considered immoral or evil; and the casino industry has attempted to redefine the notion of gambling into what is now referred to as gaming. Much of the industry is moving away from selling the "dream" toward selling individuals a new form of entertainment. This entertainment business, on a national level, is a multi-billion dollar enterprise, surpassing all other forms of entertainment. Following this line of thinking, the author provides some guidelines for youth if they do decide to gamble. The notion of harm minimization as a public health concern is an important and growing issue. If youth are going to engage in this behavior, can we teach them how to do it responsibly? The author attempts to provide some valuable guidelines addressing this very question.

The guidelines for recognizing the symptoms of out-of-control gambling, which are taken from the Council on Compulsive Gambling of New Jersey, are an excellent screening measure for youth. Similarly, the 18 questions provided to help self-identify a compulsive gambler will be very useful for teens.

The author provides much needed guidance on how and where to seek help for problem gambling. Resources as to where to seek help are provided, along with local and national help line numbers throughout the United States and Canada. Web site addresses for further information will also prove invaluable for today's youth, school counselors, social workers, educators, and mental health personnel. Particularly important is a brief, but accurate, description of several alternative forms of therapeutic help, including individual therapy, group therapy, and the Gambler's Anonymous (GA) program.

Finally, the author provides valuable information and suggestions for adolescents who have a parent, sibling, or friend with a gambling problem. This is a welcome addition and adds to the book's value.

This book has successfully met all the author's goals. It has provided adolescents and young adults, in plain and simple language, with invaluable information concerning youth gambling problems. This information is provided recognizing that adolescence is a developmental period of experimentation, thrill seeking, and risk-taking. The material is presented without moral judgments and the author never oversteps the boundaries of a non-clinician. Rather, she provides appropriate guidelines for self-evaluation and reflection and recommends that those with a problem seek help. This is a worthwhile addition for professionals and school libraries.

The author, Carol Silverman Saunders, is a magazine editor and a freelance writer for major magazines, newspapers, and book publishers. She holds a B.S. from Syracuse University.

The reviewer, Jeffrey L. Derevensky, Ph.D., is a child psychologist and Professor of School/Applied Child Psychology, Department of Educational and Counseling Psychology; Associate Professor, Department of Psychiatry; and Associate Professor, Department of Community Dentistry at McGill University. He is a clinical consultant to numerous hospitals, school boards, government agencies and corporations. Dr. Derevensky has published widely, is associate editor of the *Journal of Gambling Studies*, is co-editor of the *Canadian Journal of School Psychology*, and is on the editorial board of several journals. Dr. Derevensky is co-director of the McGill University Youth Gambling Research & Treatment Clinic.

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Web Resources

There is a large amount of information available on the World Wide Web. We list these web sites only as possible starting points on your journey. The Prevention Researcher *does not control the information presented on these sites and makes no claim as to the accuracy of the content. These descriptions and URLs were correct when we went to press, however due to the nature of the Internet, we make no claim to their future content. Inclusion in this list is not an endorsement by* The Prevention Researcher *or its publisher, Integrated Research Services, Inc.*

Athletes and Substance Abuse

Alcohol and Athletes
www.mtholyoke.edu/offices/health/ADAP/athletics.htm

This web site, by Mount Holyoke College, includes two resources: "A Coach's Guide to Recognizing Alcohol/Drug Problems Among Athletes" and "Facts for Athletes About Alcohol and Other Drugs."

Anabolic Steroid Abuse
www.steroidabuse.org

This web site is sponsored by the National Institute on Drug Abuse. It includes a research report on anabolic steroids, links to NIDA sites on steroids, and a community drug alert bulletin.

Coaches — You Can Influence Youth
www.cdc.gov/tobacco/educational_materials/yuthfax3.htm

Designed by the Center for Chronic Disease Prevention and Health Promotion, this site is for coaches and focuses on athletes and tobacco use. It includes facts about tobacco use and ideas specifically for coaches, plus links to other information on tobacco use.

Play Clean
Playclean.org

By the Office of National Drug Control Policy, this site includes a section specifically for coaches, with links to such documents as "TEAM UP: A Drug Prevention Manual for High School Athletic Coaches" and "The Coach's Playbook Against Drugs." Also included are sites specifically for athletes and parents.

Gambling

International Centre for Youth Gambling Problems and Other High-Risk Behaviors
www.education.mcgill.ca/gambling

The Centre, located at McGill University in Montreal, Canada, is actively involved in research, treatment, prevention, training, and social policy issues, both in the United States and Canada. This web site includes information specifically on youth gambling problems highlighting research conducted by staff at the Centre.

800gambler.org
www.800gambler.org

From the Council on Compulsive Gambling of New Jersey, 800gambler.org provides information on many different types of gamblers: Internet gambling, stockmarket gambling, gambling in the workplace, and women and gambling. Also included is information about adolescent gamblers and information for parents.

Responsible Gambling Council
www.cfcg.org

The mission of the Responsible Gambling Council is to ensure "healthy individuals, families, and communities that are free of the personal, social, and economic harm resulting from gambling abuse." The web site includes a large number of upcoming events (mostly international), a FAQ, and a section on the site specifically for teens. Quite possibly the best feature of this site is its search engine, called "InfoBase," which searches through their own database for news articles and research documents. Our search on "Youth" and "Research" brought up 68 search results. Each result displayed the author, source, publication date, and a brief description. Articles were from such varied sources as *Pediatrics*, the American Psychological Association, *The Wager*, and conference papers.

Gay, Lesbian, and Bisexual Youth

Healthy Lesbian, Gay and Bisexual Students Project
www.apa.org/ed/hlgb.html

The mission of the Healthy Lesbian, Gay, and Bisexual Students Project is to "strengthen the capacity of the nation's schools to prevent the behavioral health risks of lesbian, gay, and bisexual students through knowledge development, dissemination, and application, working with and through national organizations of school stakeholders." This site includes information about the health risks of LGB students and the school climate for these youth. It also includes a searchable database of over 300 publications, and a nice list of links to other resources. This project is by the American Psychological Association in collaboration with six national school health professional organizations.

Sexual Orientation: Science, Education, and Policy
psychology.ucdavis.edu/rainbow

This site was created by Dr. Gregory Herek of the Department of Psychology at the University of California, Davis. It is based on his work over the past 10 years researching gay men and lesbians in Northern California. This site includes abstracts of articles and books that Dr. Herek has published over the past decade, a number of useful links to specific reports on other sites, and data from his research.

We Are Your Children Too: Accessible Child Welfare Services for Lesbian, Gay and Bisexual Youth
www.casmt.on.ca/

This is an online publication by the Children's Aid Society of Toronto. Published in 1995, "We Are Your Children Too" was intended to guide and assist the Children's Aid Society of Toronto in ensuring an environment and services that are welcoming, accessible, and appropriate to lesbian, gay, and bisexual youth. This report includes insightful quotes from youth, workers, and foster parents, as well as information on lesbian, gay, and bisexual youth in the foster care system.

Inhalants

Inhalant Abuse: Join Together's Hot Issues
www.jointogether.org/sa/issues/hot_issues/inhalants

The Join Together web site is always an excellent source of information. The Hot Issues pages deal with a number of topics, including inhalant abuse. This page offers background on inhalant abuse, current research statistics, and links to other web sites and resource material.

Teachers. The Anti-Drug.
www.theantidrug.com/get_involved/learn_inhalants.html

The Anti-Drug web site includes a nice page on inhalants for teachers and others within the school environment. This well-designed page includes basic information about inhalants (what they are, how they are used, what the health hazards are), "tips for teachers," "what educators should know about inhalants," and signs that a youth may be using inhalants. The anti-drug site also includes information for parents (at www.theantidrug.com/ drug_info/drugs_inhalants.html).

TCADA: Inhalants
www.tcada.state.tx.us/research/inhalants

The Texas Commission on Alcohol and Drug Abuse (TCADA) provides access to an important document entitled *"Understanding Inhalant Users: An Overview for Parents, Educators, and Clinicians."* This report was updated in 1977 by Dr. Fred Beauvais, who is well known in the inhalant prevention field. Also available from this page is the fact sheet *"Inhalants: Just the Facts,"* which is a source of good information, including basic information about inhalant use.

Aboriginal Youth Net: Solvent Abuse Module
www.ayn.ca/modules/solvent

The Aboriginal Youth Network is a web site created by youth, for youth. Their "Solvent Abuse Module" is a look into Native American youth and solvent abuse, using audio clips and stories. This web resource gives a unique perspective into inhalant use and offers youth ideas on how they can help their friends. While this web site does come from Canada and gives Canadian resources it should be appropriate for Native American youth throughout North America.

Self-Injury

Focus Adolescent Services: Self-Injury and Self-Mutilation
www.focusas.com/SelfInjury.html

Billed as "an Internet clearinghouse of resources, support, and information to help your teen and heal your family," this web site has a nice set of links to more information on self-injury, although they have no unique information.

Psyke
www.ratatosk.net/psyke/selfinjury

Created and maintained by an individual in Denmark, this is a collection of material on self-injury and suicide, which the webmaster has found on other parts of the web and collected all in one place. Included here are suggestions for coping, personal stories, poetry, and links to other sites.

Tobacco Use

Campaign for Tobacco-Free Kids
www.tobaccofreekids.org

This site contains a number of "fact sheets" (in PDF format), including "Smokeless Tobacco & Youth," "Where Do Youth Smokers Get Their Cigarettes?" and "Tobacco Use Among Youth," among others. Other fact sheet topics include specific populations, tobacco control programs that work (including community-based and school-based), and tobacco's toll in the USA. These fact sheets include references to research articles and are dated so you know how current the information is. One of the unique aspects to this site is the "Tobacco Advertising Gallery" in which tobacco advertising can be searched by type, country, brand, and company. This is a political action site, there are a number of press releases, information about the annual Kick Butts Day, and information about federal and state tobacco initiatives. It is rounded out with a number of links to other web sites, grouped by topic.

Canadian National Clearinghouse on Tobacco and Health
www.ncth.ca

The mission of the National Clearinghouse on Tobacco and Health is to provide information and networking services for tobacco use prevention, reduction, and intervention in Canada. This site contains a number of fact sheets, a frequently asked questions (FAQ) page, statistics of Canadian tobacco use, a number of publications available in PDF format, and a "gallery" of tobacco photographs, advertisements, and posters from tobacco companies. This site is available in English and French.

Kick Butts Day
www.kickbuttsday.org

Occurring annually in April, Kick Butts Day "is an annual initiative that encourages activism and leadership among elementary, middle, and high school students. It's the day America's kids stand up to tobacco, and America's adults stand up for kids." This site includes ideas of a number of activities that can be organized, complete with an estimated cost, estimated time for preparation, and the number of adults needed to supervise. Information is also provided on how to get the Kick Butts Day activity noticed (e.g., a news release template is provided).

PrevLine
www.health.org

PrevLine contains a number of documents on tobacco, including pamphlets, brochures, and reports. Two booklets are especially of interest: *"Reducing Tobacco Use Among Youth: Community Based Approaches, A Guideline for Prevention Practitioners"* (a www.health.org/govpubs/PHD745/toc.htm), and *"Reducing Tobacco Use Among Youth: Community Based Approaches, A Community Guide"* (at www.health.org/govpubs/PHD744/).

Smelly Puking Habit
smellypukinghabit.com

Smellypukinghabit.com is one part of a mass media campaign by the Arizona Department of Health Services Tobacco Education and Prevention Program. It is a multi-media web site using sound, text, games, and flash media to relay the harms done by smoking cigarettes, give a history of smoking, and tips on quitting.

Tobacco Bulletin Board Service
www.tobacco.org

This site is different from any other tobacco site we've encountered on the Web. Besides information on smoking and health, cessation resources, and up-to-date news reports, it also contains an extensive list of Internet resources, a history of tobacco, a tobacco timeline, and quotes and alerts.

Did you know that you can send articles from our web site, www.TPRonline.org, directly tc your friends and colleagues via e-mail?

Tell a friend

Visit our web site, select an article and then click on the "Tell a friend" link. It's a fast and easy way to get information out to those who need it.

BOOK REVIEW

The Other America: Gay & Lesbian Youth

By Gail B. Stewart
Reviewed by Lyndsey Davies, M.S.W.

1997. San Diego, CA: Lucent Books.
ISBN 1-56006-337-8

In February 2001, *The Prevention Researcher* outlined the issues and struggles facing lesbian and gay youth, both in the wider community and particularly in the school system. Among the issues identified was one of a lack of available resources and information. It was noted that this leads to a sense of isolation, in turn leading to depression and, for some lesbian and gay youth, suicide. Within the schools, problems ranged from a lack of lesbian/gay content in the course curriculum to harassment, and verbal and physical abuse. These issues, and the way they affected four lesbian and gay youths, form the basis of the book *The Other America: Gay and Lesbian Youth*.

The Other America series sets out to humanize marginalized sectors of American society through the presentation of individual members of those sectors. The author, Gail B. Stewart, states that her hope is that through this individualization, the reader will gain a realization that people cannot be "identified by condition – a disease, crime, morality, poverty" (p.6). In this book, the "condition" is that of homosexuality. The author interviews two lesbian and two gay youths who, through telling their own very different stories, confirm and highlight the author's points.

The Other America: Gay and Lesbian Youth is a very easy book to read that portrays the struggles and successes of four young people. It is written for the adolescent reader, although anyone working with youth would also do well to read it as it offers an excellent snapshot of the diversity within the lesbian and gay community, while poignantly recounting the difficulties of being a member of that community, particularly for its youth.

The book offers a succinct introduction, which outlines the historical, and predominantly negative perceptions of homosexuality, together with today's relatively unchanged views. The author begins by relating the story of a 15-year-old girl who killed herself because of her lesbianism. In this way, Stewart highlights the very real risks posed to lesbian and gay youth stemming from society's homophobic attitudes and the emotionally damaging, and often physically violent, ways in which those attitudes are manifested.

The largest portion of the book is divided into four chapters, each detailing the stories of one of the four young people interviewed. These chapters are punctuated with numerous photographs of the individual with family or friends, which serve to bring the storyteller to life. Although each individual's story is very different from the other three, the author asks each of them how and when they first acknowledged their sexual orientation ("came out"); the impact of this on themselves, their family, and their friends; what their lives have been like; and their thoughts for the future.

The first chapter is on Tori, a young African-American woman who talks about having known she was a lesbian since age six. Tori reports that she received a generally supportive and accepting reaction from her family and, at the time of writing the book, is in a positive relationship with her girlfriend of six months.

Joe is a 16-year-old biracial boy whose story focuses more on his abusive childhood and the impact of that than it does on his being gay. He tells of his numerous stays in foster homes, group homes, and with various family members. His story serves to reinforce the diversity of gay youth in that, for Joe, surviving an abusive and disrupted childhood is at least as big a part of his history as growing up gay is.

Justin is a 17-year-old who probably experienced the most difficulty with his sexual identity out of the four young people interviewed. Justin talks of always having known he was gay and his depression when he realized that "it was kids like me that other kids made 'fag' jokes about" (p.62). This story deals more than the others do with the fear, isolation, and pressures involved with trying to avoid being labeled gay and not being oneself with friends and family.

Nikki, 20 years old, a Korean woman who was adopted at six months of age, is the oldest of the four interviewees. Nikki's story most closely resembles the "American Dream" as she talks of her close-knit "do-the-right-thing family" (p.91) and her university life. She reports that she did not come out until entering the university, but since then has been heavily involved with the campus Gay, Lesbian, Bisexual, and Transgendered organization.

Stewart sets out to debunk the stereotypes of lesbians and gays and she manages this on two levels within the book. First, the four people whose stories she relates are widely differing in their culture, ethnicity, family background, and experiences of being lesbian or gay. They therefore, in and of themselves, challenge the stereotypes. Second, each of the young people talk, to varying degrees, about their own perceptions of those stereotypes. They all refute the myth that one can tell who is lesbian or gay by looks or mannerisms.

At the end of the book, the author includes an epilogue that gives a synopsis of what the four young people are doing currently. It concludes with a list of ways in which young people can help their community become more inclusive and supportive of lesbian and gay youth, together with a small list of resources.

If there is one consistent message within the four stories, it is pointing to the lack of available resources, support, and information for lesbian and gay youth. Ensuring that books such as this are available in school libraries and visible in counselor's offices will go some way to alleviating that sense of difference and isolation. Overall, I think this book is a valuable resource which will challenge some mainstream assumptions of what it means to be a lesbian or gay youth.

The author, Gail B. Stewart, has written more than eighty books for children and young adults. She lives in Minneapolis, Minnesota.

The reviewer, Lyndsey Davies, M.S.W., R.S.W., is currently working as a therapist in the Youth Program, Addiction Services at the Centre for Addiction and Mental Health. Prior to working in the Youth Program she worked in the Lesbian, Gay, Bisexual Program at the Centre for Addiction and Mental Health.

BOOK REVIEW

Social Services with Transgendered Youth

Edited by Gerald P. Mallon, D.S.W.
Reviewed by Farzana Doctor, M.S.W.

1999. New York: Harrington Park Press.
ISBN: 1-56023-136-X

Social Services with Transgendered Youth is the first published book of its kind. Its eight articles provide information and thought-provoking case examples suited for those who have little awareness of this population, as well as those who have already begun to learn about the experiences of transgendered youth and wish to expand their knowledge. What is different about the articles in this volume is that the authors' perspectives aim to challenge the traditionally held view that transgendered and gender non-conforming youth have psychiatric disorders.

As someone working to create transgendered/transsexual inclusion within a gay, lesbian and bisexual identified social service, I found the practical suggestions and information in this book particularly interesting and relevant. Issues relating to diverse sexualities and genders are new to many of us working in social services or in the helping professions. Agencies and professional schools are only just beginning to integrate anti-oppressive policies and education in working with gay, lesbian, and bisexual people. As service providers, we have begun to challenge heterosexist notions of opposite-gender pairings as normal and preferable.

We are much further behind in our understanding of the gender spectrum, and are perhaps accustomed to thinking only within the binary system of only-male and only-female. It is incumbent upon us that we begin the process of challenging transphobic myths and assumptions in our work with transgendered and gender non-conforming people. This volume is a helpful tool for this process.

The articles cover issues related specifically to children and youth. They highlight the oppression and violence faced by these young people in their families, schools, and communities. Many include a review of the sparse literature in this area and provide a historical and social context for sources of knowledge. Finally, the book provides a helpful glossary of definitions and a guide for staff self-awareness.

Gerald P. Mallon's three articles include basic concepts for understanding transgendered identity in children and youth, and also highlight the social worker's responsibility in preparing him/ herself to work with this population. In "Practice with Transgendered Children" there is a list of recommendations to guide clinicians in enhancing their own practice, including educating parents, opposing treatments that attempt to impose gender conformity and gender stereotypical behaviors, and providing validation to transgendered youth. His final article, "A Call for Organizational Trans-Formation" provides examples of agencies that are trans-positive and suggests concrete ways to create organizational change through hiring, training, policies, and advocacy.

Of note is an article by Sophia Pazos, which discusses the experiences of female to male (FTM) youth. She states that many FTM youth experience some early tolerance of their "tomboyishness" until they reach puberty, while others are verbally or physically assaulted from a young age. Pazos' interviewees experienced puberty as an abrupt end to their ability to fantasize and see themselves as male. Dating relationships and the complex intersections between sexual orientation and gender identity are also discussed. For example, Pazos describes the dilemmas faced by those FTM youth who may be heterosexual identified (dating girls or women), but seen by others as lesbian. Some may identify as lesbian and FTM. Others may be gay identified, but may not want to relate to their male lovers with a female body. Some may choose to not date at all, or may date many males in an attempt to prove themselves "normal." Clearly, this diversity in experiences suggests that those in the helping professions must avoid making assumptions about gender and sexual orientation and should listen carefully and non-judgmentally to how the young person identifies. She also discusses the role of the Internet as a tool to reduce isolation and build community for this marginalized and mostly invisible group.

Through case illustration, Rebecca Klein discusses the experiences of working with male to female (MTF) sex workers. She describes the use of group work to reduce shame and internalized transphobia, and to address practical issues such as employment, life skills and identity. She provides a list of group work "tips" to assist the service provider.

Christian Burgess reviews definitions and the current debate to remove the Gender Identity Disorder classification from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. His article urges social service providers to be aware of the internal and external pressures faced by transgendered youth in their identity formation, rather than seeing their gender non-conformity as a disorder.

Ken Cooper discusses the confusion faced by family members of a transgendered young person. He states that the role of the social service provider is to help family members grieve the loss of the relationship with the young person as they knew it and support them to reframe it and accommodate the changes. For example, this may involve helping parents to understand the continuum of gender identities or encouraging them to begin referring to a biological son as "my daughter." He also discusses the need to assist transgendered youth to build chosen families and communities in order to build additional support for themselves.

Social services have had a poor record in working with transgendered youth in ways that respect their autonomy and diversity. What this volume suggests is that there are concrete ways in which youth-serving professionals can create change in our agencies, schools, and communities.

The editor, Gerald P. Mallon, D.S.W., is Assistant Professor at the City University of New York at Hunter College School of Social Work. Dr. Mallon's research interests focus on the experience of gay, lesbian, bisexual and transgendered children, youth, and families within the context of child welfare service delivery. He is also the author of several books, including: *We Don't Exactly Get the Welcome Wagon: The Experience of Gay and Lesbian Adolescents in Child Welfare Systems* (Columbia University Press, 1998), and *Foundations of Social Work Practice with Lesbians and Gay Persons* (The Haworth Press, Inc., 1998).

The reviewer, Farzana Doctor, M.S.W., is a South Asian lesbian who works with GLBT people at the LesBiGay Service at the Centre for Addiction and Mental Health in Toronto, Ontario. She has worked with this community since 1993.

Publications Available for Free

The following are reports and publications available for free on the Internet and, in some cases, by phone. We list these documents as a service to our readers and take no responsibility for their accuracy.

Internet addresses may be case sensitive. We suggest you type them exactly as they appear here. While we strive to list reports only from reputable, stable organizations, Internet addresses seem to always be in a state of transition. These Internet addresses were correct when we went to press.

Athletes and Substance Abuse

Alcohol Use in Adolescents: The Scope of the Problem and Strategies for Intervention
www.physsportsmed.com/issues/2000/06_00/schwenk.htm

Published June 2000. An article from *The Physician and Sportsmedicine*, this focuses specifically on the problem of alcohol use among adolescent athletes.

Anabolic Steroid Use by Male and Female Middle School Students
www.pediatrics.org/cgi/content/full/101/5/e6

Published May 1998. This article, published by *Pediatrics* and written by Avery Faigenbaum, focuses on the use of anabolic steroids by a sample of 5th, 6th and 7th graders in Massachusetts.

Gangs

1998 National Youth Gang Survey
HTML: www.ncjrs.org/html/ojjdp/jjsum_11_00
PDF: www.ncjrs.org/pdffiles1/ojjdp/183109.pdf

Published November 2000, 86 pages (in PDF format). This report summarizes the results of the 1998 National Youth Gang Survey (a survey based on a sample of 3,018 police and sheriff's departments). The report discusses the prevalence of youth gangs, demographics of youth gang members, and youth gang crime, among other topics.

Cultural Explanations for Vietnamese Youth Involvement in Street Gangs
www.ncjrs.org/pdffiles1/ojjdp/180955.pdf

Published June 1998, 97 pages. A final report to the federal Office of Juvenile Justice and Delinquency Prevention. The authors, Douglas R. Kent and George T. Felkenes examine the relationship between gang involvement and delinquency in communities with a large number of Vietnamese refugee families in southern California. The study of Vietnamese street gangs is rather unique because they are relatively recent phenomena. Individual involvement in Vietnamese street gangs is generally free of familial and generational influences which affect street gang members of other ethnicities.

Youth Gang Programs and Strategies
HTML: www.ncjrs.org/html/ojjdp/summary_2000_8/home.html
PDF: www.ncjrs.org/pdffiles1/ojjdp/171154.pdf

Published August 2000, 86 pages (in PDF format). Written by James C. Howell of the National Youth Gang Center, this report draws on more than a half-century of gang program evaluations and summarizes what has been learned about prevention, intervention, and suppression programs.

Gay, Lesbian, and Bisexual Youth

Academic and Career Choices for Lesbian and Gay Young Adults
icdl.uncg.edu/ft/050100-01.html

Published 1999, 10 pages. Written by Margaret Schneider and Joan McCurdy-Myers, this short report is only available in PDF format. It examines the influence of sexual orientation on academic and career choices.

Hatred in the Hallways: Violence and Discrimination Against Lesbian, Gay, Bisexual, and Transgendered Students in U.S. Schools
www.hrw.org/reports/2001/uslgbt

Published May 2001. Written by Michael Bochenek and A. Widney Brown, and published by Human Rights Watch, this report is based on in-depth interviews with 140 youth and 130 teachers, administrators, counselors, parents, and youth service providers. It looks at the human rights abuses suffered by LGBT students by their peers. This report includes a number of recommendations for school counselors, teachers and administrators, school boards and schools, state and federal governments.

Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual, and Transgendered Health
www.glma.org/policy/hp2010

This document is the result of a collaborative effort coordinated by the Gay and Lesbian Medical Association. They report that it is the first-ever comprehensive document on the state of LGBT health. It was written for health care consumers, providers, educators, government agencies, schools, clinics, and health professionals in all settings.

Just the Facts About Sexual Orientation & Youth: A Primer for Principals, Educators & School Personnel
www.nea.org/achievement/gayfacts.pdf

Published 1999, 13 pages. Published jointly by a number of institutions including the American Academy of Pediatrics, the American Counseling Association, the Interfaith Alliance Foundation, the National Association of Social Workers, and the National Education Association, *Just the Facts* provides information from physicians, counselors, social workers, psychologists, and others who are knowledgeable about the development of sexual orientation in youth and the issues raised by "reparative therapy" and "transformational ministry."

Inhalants

Inhalant Abuse: National Institute on Drug Abuse Research Report
www.drugabuse.gov/ResearchReports/inhalants/inhalants.html

Revised July 2000. Published by the National Institute on Drug Abuse, *Inhalant Abuse* discusses the patterns of inhalant abuse, how inhalants are used, short- and long-term effects, and medical consequences of inhalant use, among other topics. A link to a PDF version of this report is also available on this web site.

Inhalant Prevention Resource Guide
www.pen.k12.va.us/VDOE/Instruction/Inhalantbook.pdf

Published January 2001, 88 pages. Written by Isabel Burk, this guide is available from the Virginia Department of Education. It details the basics of inhalants, such as the scope of the problem, what products are abused and why, and the effects, signs, and symptoms of inhalant abuse. The author also discusses school drug policies, and ideas for prevention activities in the classroom. It is only available in PDF format.

Pregnancy Prevention

Get Organized: A Guide to Preventing Teen Pregnancy
aspe.hhs.gov/hsp/get-organized99

Published September 1999. Written by the National Campaign to Prevent Teen Pregnancy, this tool kit was designed for people at the state and local levels trying to prevent teen pregnancy in their communities. It includes strategies for involving youth, parents, the faith community, schools, and others. Also included are promising approaches to preventing teen pregnancy, a needs assessment, and evaluations. Available in PDF format only, each of the 17 chapters of this report is listed separately for easier download.

Why is Teenage Pregnancy Declining?
The Roles of Abstinence, Sexual Activity and Contraceptive Use
www.agi-usa.org/pubs/or_teen_preg_decline.html

Published December 1999, 23 pages. The Alan Guttmacher Institute is a non-profit organization which focuses on reproductive health research, policy analysis, and public education. Their mission is to protect the reproductive choices of all women and men in the United States and throughout the world. There are a variety of reports available on their web site (www.agi-usa.org). *Why is Teenage Pregnancy Declining?* uses current data to examine the drops in teenage pregnancy and examines how abstinence, changes in sexual behavior, and changes in contraceptive use have contributed to these declines. This report is available in PDF and HTML format.

Tobacco Use

Reducing Tobacco Use: A Report of the Surgeon General
www.cdc.gov/tobacco/sgr_tobacco_use.htm

Published August 2000. Full Report 474 pages. According to the press release from the US Department of Health and Human Services, this report by Surgeon General David Satcher, "is the first-ever report to provide an in-depth analysis of the effectiveness of various methods to reduce tobacco use— educational, clinical, regulatory, economic, and social." It examines both adult and adolescent tobacco use. Chapter titles include "Issues in Reducing Tobacco Use," "A Historical Review of Efforts to Reduce Smoking in the United States," "Effective Educational Strategies to Prevent Tobacco Use Among Young People," and others. The full report (available in PDF format) is downloadable from the web site either in its entirety or by chapters. It is also available by calling 770-488-5705. The web site also includes several fact sheets.

Violence

Best Practices in Reducing School Violence:
A Source Book for Community Action
www.cdc.gov/ncipc/dvp/bestpractices.htm

Published September 2000, 216 pages. According to the preface, the editors of this publication have "pulled together the best practices known for four promising strategies to prevent youth violence." These four strategies include parent- and family-based strategies, home-visiting strategies, social-cognitive strategies, and mentoring strategies. *Best Practices* is available either online in PDF format or by ordering a free copy either from the above URL or calling toll-free 888-252-7751.

Blueprints for Violence Prevention
HTML: www.ncjrs.org/html/ojjdp/jjbul2001_7_3/contents.html
PDF: www.ncjrs.org/pdffiles1/ojjdp/187079.pdf

Published July 2001, 16 pages (in PDF format). Written by Sharon Mihalic, Katherine Irwin, and colleagues for the Office of Juvenile Justice and Delinquency Prevention, this bulletin provides information for communities on a wide array of violence prevention and intervention programs that have proven to be effective. Contact information is available for each program.

Guide for Preventing and Responding to School Violence
www.theiacp.org/pubinfo/pubs/pslc/svindex.htm

Published 2000, 75 pages (in PDF format). This document is published by the International Association of Chiefs of Police. The purpose "is to present different strategies and approaches for members of school communities to consider when creating safer learning environments." The roles of school staff and administrators, students, parents, law enforcement, and the community are discussed. It is available in both HTML and PDF formats.

Measuring Violence-Related Attitudes, Beliefs, and Behaviors Among Youths: A Compendium of Assessment Tools
www.cdc.gov/ncipc/pub-res/measure.htm

Published 1998, 267 pages. Published by the Division of Violence Prevention of the Centers for Disease Control and Prevention, this report is available online (in PDF format) or may be ordered from this web site. The purpose of this report is to provide researchers and prevention specialists with a set of tools to evaluate programs to prevent youth violence.

School Violence: An Overview
(Juvenile Justice Journal, Volume VIII, Number 1)
HTML: www.ncjrs.org/html/ojjdp/jjjournal_2001_6
PDF: www.ncjrs.org/pdffiles1/ojjdp/188158.pdf

Published June 2001, 40 pages (in PDF format). This report includes three articles: "School Violence: An Overview" by Margaret Small and Kellie Dressler Tetrick, "Creating Safe Schools: A Comprehensive Approach" by Ira Pollack and Carlos Sundermann, and "Conflict Resolution Education: Preparing Youth for the Future" by Donna K. Crawford and Richard J. Bodine. It is also available by calling 800-638-8736.

Youth Violence: A Report of the Surgeon General
www.surgeongeneral.gov/library/youthviolence

Published January 2001. Available only in HTML format, this report is the result of a collaboration between the federal offices of the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the National Institute for Mental Health. This report looks at the research conducted on youth violence and its prevalence. It also discusses the risk factors related to youth violence, and the protective factors that seem to keep youth from following this path. It concludes with a look at the effectiveness of programs designed for prevention and intervention.

Subject Index

This cumulative topic index reflects the past eight years of The Prevention Researcher. *This will assist you in finding articles in our back issues. Additionally, several of these articles are available on our web site. Back issues may be bought from our secure online server (at www.TPRonline.org) or by calling 800-929-2955 ext. 19.*
This index has one or more entries for each item published. The name of the first author is in brackets following each article title.

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